

9203

CERTIFICATE OF DEATH

09177

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ohio b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 63 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Donald Middle Ray Last Adams, Jr.				4. DATE OF DEATH Month August Day 21 , Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1955	
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 6 Days 19		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Donald R. Adams, Sr.				14. MOTHER'S MAIDEN NAME Marcella Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Lymphoblastic Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 9 mos.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from June 19, 19 58 , to August 21, 19 58 , that I last saw the deceased alive on August 21, 19 58 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Richard Lee				DATE SIGNED 8/21/58			
PHYSICIAN'S NAME (Type) G. Richard Lee, M. D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/58		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Jackhorn, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE AUG 22 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00177

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
Theodore J. Gorman		Male		35		August 27, 1893		St. Louis, Mo.	
Cause of Death		Manner of Death		Period of Incubation		Time of Death		Place of Death	
Pneumonia		Natural		None		August 27, 1928		St. Louis, Mo.	
Occupation		Education		Religion		Marital Status		Social Status	
None		None		Catholic		Single		None	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Certificate		Name of Registrar		Name of Informant		Name of Witness	
August 27, 1928		St. Louis, Mo.		Theodore J. Gorman		Theodore J. Gorman		Theodore J. Gorman	

RECEIVED
BUREAU OF VITALS
MISSOURI STATE DEPARTMENT OF HEALTH
ST. LOUIS, MO.
AUG 28 1928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9178

CERTIFICATE OF DEATH

09178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		d. STREET ADDRESS <u>6729 Piney Br. Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Isabella (NMN.) Alexander</u>		4. DATE OF DEATH <u>Aug. 12 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-74</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Alexander Davidson</u>		14. MOTHER'S MAIDEN NAME <u>Susan Angus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Son</u>		Address <u>10023 Greenock Rd. SS., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage c.</u> 331X DUE TO <u>Aphasia & Left Hemiplegia</u> (b) <u>Arterial Hypertension</u> DUE TO <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Undetermined</u> <u>Undetermined</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED <u>While</u> <input type="checkbox"/> <u>Not while</u> <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1952</u> to <u>Aug 12, 1958</u> , that I last saw the deceased alive on <u>Aug 11, 1958</u> , and that death occurred at <u>3:07</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.		ADDRESS (Street, city or town, state) <u>2835 Eastern Ave.</u> DATE SIGNED <u>Aug 14 1958</u>	
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		<u>Blue Spring Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 15, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Canal St NW 20C</u>	
24a. REG'D BY REGISTRAR <u>Aug 14 58</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

CERTIFICATE OF DEATH

0112

See 1-1-19

NAME OF DEATH

MATERNITY

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF INTERMENT

DATE OF INTERMENT

PLACE OF BURIAL

DATE OF BURIAL

PLACE OF CREMATION

DATE OF CREMATION

PLACE OF EXHUMATION

DATE OF EXHUMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

W

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE COMMISSIONER OF HEALTH. IT IS THE DUTY OF THE COMMISSIONER OF HEALTH TO PRESERVE THIS RECORD AND TO MAKE IT AVAILABLE TO THE PUBLIC.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9204

CERTIFICATE OF DEATH

Reg. Dist. No. 09179

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANITARIUM</u>		d. STREET ADDRESS <u>7419 PINNEY BRANCH RD</u>	
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>ANDERSON</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 31, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BARTON LOWE</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS IRENE BRUNGART</u>		Address <u>7419 PINNEY BRANCH RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis Generalized Sclerosis</u> DUE TO <u>10 years</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>APR. 1, 1958</u> , to <u>1 Aug. 1958</u> , that I last saw the deceased alive on <u>31 July 1958</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Zeeba</u> M.D. <u>7112 Willow Ave</u>		ADDRESS (Street, city or town, state) <u>INDIANA</u> DATE SIGNED <u>1 Aug 1958</u>	
PHYSICIAN'S NAME (Type) <u>H. B. ZEEBA</u>		<u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG 3 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HANOVER CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MORRISTOWN, INDIANA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Valters</u>		ADDRESS <u>254 Lowell St</u>	
24a. REC'D BY REGISTRAR <u>D.B.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>2800 Jutland Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2800 Jutland Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Othelia Dressel Anderson</u>		4. DATE OF DEATH <u>Aug 3 1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Dressel</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Pankin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>122-09-2740</u>	
17. INFORMANT <u>B. D. Anderson (husband)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive heart disease</u> <u>434.1</u> DUE TO (b) <u>Abdominal Aortic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-3-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>AUG 5 58</u>		DATE <u>AUG 5 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Pumphrey</u>			

FOR STATE
HEALTH DEPT

DEATH BOOK

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

1. Name of Deceased: John Doe

2. Age: 45 Sex: Male

3. Date of Death: Jan 15 1918

4. Place of Death: Home

5. Cause of Death: Heart Disease

6. Medical History: None

7. Signature of Medical Examiner: [Signature]

8. Date of Examination: Jan 15 1918

9. Place of Examination: Home

10. Name of Physician: Dr. Smith

11. Address of Physician: 123 Main St

12. City: Baltimore State: Md

13. County: Harford

14. District: 1st

15. Ward: 1st

16. Block: 1st

17. Lot: 1st

18. Sublot: 1st

19. Section: 1st

20. Subsection: 1st

21. Block: 1st

22. Lot: 1st

23. Sublot: 1st

24. Section: 1st

25. Subsection: 1st

26. Block: 1st

27. Lot: 1st

28. Sublot: 1st

29. Section: 1st

30. Subsection: 1st

31. Block: 1st

32. Lot: 1st

33. Sublot: 1st

34. Section: 1st

35. Subsection: 1st

36. Block: 1st

37. Lot: 1st

38. Sublot: 1st

39. Section: 1st

40. Subsection: 1st

41. Block: 1st

42. Lot: 1st

43. Sublot: 1st

44. Section: 1st

45. Subsection: 1st

46. Block: 1st

47. Lot: 1st

48. Sublot: 1st

49. Section: 1st

50. Subsection: 1st

51. Block: 1st

52. Lot: 1st

53. Sublot: 1st

54. Section: 1st

55. Subsection: 1st

56. Block: 1st

57. Lot: 1st

58. Sublot: 1st

59. Section: 1st

60. Subsection: 1st

61. Block: 1st

62. Lot: 1st

63. Sublot: 1st

64. Section: 1st

65. Subsection: 1st

66. Block: 1st

67. Lot: 1st

68. Sublot: 1st

69. Section: 1st

70. Subsection: 1st

71. Block: 1st

72. Lot: 1st

73. Sublot: 1st

74. Section: 1st

75. Subsection: 1st

76. Block: 1st

77. Lot: 1st

78. Sublot: 1st

79. Section: 1st

80. Subsection: 1st

81. Block: 1st

82. Lot: 1st

83. Sublot: 1st

84. Section: 1st

85. Subsection: 1st

86. Block: 1st

87. Lot: 1st

88. Sublot: 1st

89. Section: 1st

90. Subsection: 1st

91. Block: 1st

92. Lot: 1st

93. Sublot: 1st

94. Section: 1st

95. Subsection: 1st

96. Block: 1st

97. Lot: 1st

98. Sublot: 1st

99. Section: 1st

100. Subsection: 1st

9206

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fauquier	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 38 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mason Middle Fitzhugh Last Ball		4. DATE OF DEATH Month August Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1897
9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitation Inspector		10b. KIND OF BUSINESS OR INDUSTRY Sanitation	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles F. Ball		14. MOTHER'S MAIDEN NAME Bessie Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Vein Thromboses with infarction of bowel DUE TO (b) Status post splenectomy for splenomegaly DUE TO (c) Myeloid metaplasia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, Renal lithiasis, shock		INTERVAL BETWEEN ONSET AND DEATH 12 days 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1958 , to August 17, 1958 , that I last saw the deceased alive on August 17, 1958 , and that death occurred at 6:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman R. Gevertz		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-18-58	
PHYSICIAN'S NAME (Type) Norman R. Gevertz, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/20/58	
22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		22d. LOCATION (City, town, or county) (State) Upperville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR AUG 20 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

50

1

2

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of business		24. Signature of government	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	

9208

CERTIFICATE OF DEATH

09183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
c. LENGTH OF STAY IN TB <u>3 mo.</u>		d. STREET ADDRESS <u>4707 Chevy Chase Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4707 Chevy Chase Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Muriel Catherine Barnes</u>		4. DATE OF DEATH Month Day Year <u>Aug 8 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Amberson C. Hardy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walstrom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Henry B. Barnes</u>		Address <u>Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of ovary, with metastases</u> DUE TO (b) <u>175.0</u> DUE TO (c) <u>1 yr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1957</u> to <u>Aug 8 1958</u> , that I last saw the deceased alive on <u>Aug 7 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u>		ADDRESS (Street, city or town, state) <u>7701 Cav. Dr. Prince Georges County, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		DATE SIGNED <u>8-8-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St., N.W. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Aug 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be used for the purpose of removing the body. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09182

9207

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium</u>				d. STREET ADDRESS <u>3412 Rittenhouse St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Archy</u> Middle <u>Wright</u> Last <u>Barnes</u>				4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 21, 1891</u>	
9. AGE (In years, lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>naval officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. supply</u>			
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Oscar O. Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Frances Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1898-1935</u>				16. SOCIAL SECURITY NO. <u>1898-1935</u>			
17. INFORMANT <u>daughter</u> Address <u>Bethesda, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>5-10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral arteriosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>56</u> , to <u>August</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 14</u> , 19 <u>58</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmentraut</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda, Md.</u> DATE SIGNED <u>8/26/58</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmentraut M.D.</u>				22a. REC'D BY REGISTRAR			
22b. DATE THEREOF <u>8/29/58</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				DATE <u>AUG 28 '58</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED HARRIS		2. SEX M		3. AGE 37		4. DATE OF BIRTH 1901		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION LABORER		7. MARITAL STATUS MARRIED		8. COLOR WHITE		9. RELIGION METHODIST		10. EDUCATION HIGH SCHOOL	
11. CAUSE OF DEATH HEART DISEASE		12. PLACE OF DEATH HOME		13. DATE OF DEATH 1938		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF PHYSICIAN J. H. HARRIS	
16. SIGNATURE OF REGISTRAR J. H. HARRIS		17. SIGNATURE OF WITNESS J. H. HARRIS		18. SIGNATURE OF WITNESS J. H. HARRIS		19. SIGNATURE OF WITNESS J. H. HARRIS		20. SIGNATURE OF WITNESS J. H. HARRIS	

50
1938
BALTIMORE, MARYLAND
JANUARY 1, 1938
J. H. HARRIS

9209

CERTIFICATE OF DEATH

Reg. Dist. No. 09184

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>5324 Saratoga Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Houston Bearden</u>				4. DATE OF DEATH Month Day Year <u>8 14 1958</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9 1882</u>	9. AGE (In years last birthday) <u>76 1/2</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>L & N Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
13. FATHER'S NAME <u>Samuel H. Bearden</u>				14. MOTHER'S MAIDEN NAME <u>Louise Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wife Mrs Lillian Bearden</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Terminal</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion & Infarction</u> DUE TO (c) <u>Arterio Sclerosis Generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>48 h.</u> <u>10 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493 HemiPlegia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>16 July, 1958</u> , to <u>date</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Aug.</u> , 19 <u>58</u> , and that death occurred at <u>4:05</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John G. Ball</u>				ADDRESS (Street, city or town, state) <u>7936 Georgetown Rd.</u> DATE SIGNED <u>14 Aug 58</u>			
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>				<u>Bethesda. 14 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/16/58</u>		<u>Parklawn Cem.</u>		<u>Rodenville Pike Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home, Nt. Heights</u>				24. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		25. RECEIVED BY REGISTRAR <u>AUG 18 1958</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is valid for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9210

CERTIFICATE OF DEATH

09185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park 17</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>804 Maplewood Ave.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Wilhelmina Bauer Becker</i>		4. DATE OF DEATH Month Day Year <i>Aug. 6 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 2. 1879</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>North Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Bauer</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Yungner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>585X</i> IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Septicemia</i> DUE TO (c) <i>Acute cholecystitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 days</i> <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/16</i> , 19 <i>58</i> , to <i>8/6</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8/6</i> , 19 <i>58</i> , and that death occurred at <i>7:45</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eino Magi</i>		DATE SIGNED <i>8/6/58</i>	
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		ADDRESS (Street, city or town, state) <i>918 Univ. Blvd. E., Silver Spring, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Aug 10-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Beltside Cemetery</i>	22d. LOCATION (City, town or county) (State) <i>Theriot, Canada</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Hallers</i>		24. REC'D BY REGISTRAR <i>Theriot</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur Hallers</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7 & 8, Film G-233 8/29/58.cac.

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>17 yrs</u>		d. STREET ADDRESS <u>17216 Willow Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7216 Willow Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Caroline Gibson Berry</u>		4. DATE OF DEATH <u>Aug 13 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-91</u>
9. AGE (in years last birthday) <u>67 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Court</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Wm E Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Mary I. Todd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5601 Col. Ave NW. Wash. D.C.</u>	
17. INFORMANT <u>Mary Berry Vann</u>		Address <u>5601 Col. Ave NW. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach & liver</u> 151X DUE TO (b) <u>with generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>August 15 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10. *Examine the following text and answer the questions that follow.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

9211

CERTIFICATE OF DEATH

09187

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5508 Oakmont Avenue		d. STREET ADDRESS 5508 Oakmont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HERBERT BILlich		4. DATE OF DEATH Month Day Year August 13, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1900	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 10 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Engineer		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Daniel Billich		14. MOTHER'S MAIDEN NAME Sarah Miller		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 187-09-3094		17. INFORMANT Mildred Billich-Item#2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Coronary arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 15 min. 1 hr. Indef.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetic Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Mar. 1, 1951 , to 8/13/58 , that I last saw the deceased alive on 8/13/58 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Stephen Jones		ADDRESS (Street, city or town, state) 809 Viers Mill Road, Rockville, Md.		DATE SIGNED 8/14/58	
PHYSICIAN'S NAME (Type) 809 Viers Mill Road, Rockville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/58		22c. NAME OF CEMETERY OR CREMATORY Parklawn	
22d. LOCATION (City, town, or county) Rockville, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR AUG 15 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9212 Item 19 Film G232 8-19-58 et
CERTIFICATE OF DEATH

09188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 82 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington 47X-3 d. STREET ADDRESS 2110 F Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Ann Middle Regina Last Bishop		4. DATE OF DEATH Month August 12, Day 19 Year 58		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 24, 1906		9. AGE (In years last birthday) 51 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.													
13. FATHER'S NAME John McCullough				14. MOTHER'S MAIDEN NAME Minnie Lynch																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 100-16-2772		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain metastasis - carcinoma of Cervix Uteri DUE TO (c) Carcinoma of Cervix Uteri PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 15 min. 1 yr. 3 yrs.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)														
21. I certify that I attended the deceased from May 22 , 19 58 , to August 12 , 19 58 , that I last saw the deceased alive on August 12 , 19 58 , and that death occurred at 4:10A M. , from the causes and on the date stated above.																					
ACTUAL SIGNATURE <i>Marvin M. Ramsdahl</i> M.D.						ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			DATE SIGNED 8/12/58												
PHYSICIAN'S NAME (Type) Marvin M. Ramsdahl, M. D.																					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8/14/58		22c. NAME OF CEMETERY OR CREMATORY St. Elmo			22d. LOCATION (City, town, or county) (State) Washington, D.C.													
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valley's Funeral Home</i> <i>Inc.</i>						ADDRESS mt. Rainier Ind.			24a. REC'D BY REGISTRAR DATE AUG 18 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

9213

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09189

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County Gen. Hosp.		d. STREET ADDRESS RFD # 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Barry Dennis Boccabella		4. DATE OF DEATH Month Aug. Day 29 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/51
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY student	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Raymond G. Boccabella	
14. MOTHER'S MAIDEN NAME Helen Irene Skelton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Hosp. Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema & laceration 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bullet wound thru skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Playing with 32 cal. revolver			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days
20c. TIME OF INJURY Month, Day, Year 1:23 p.m. 8/27/58 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home			20f. (City or town) (County) (State) Olney Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 8/29/58	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 2, 1958	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Rumphrey		24a. REC'D BY REGISTRAR SEP 2 '58	
24b. REGISTRAR'S SIGNATURE Charles L. House		24c. ADDRESS SILVER SPRING, MD.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00158

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan. 1, 1900		New York City	
Occupation		Cause of Death		Manner of Death		Place of Death		Date of Death	
Teacher		Heart Disease		Natural		Home		Jan. 15, 1945	
History of Illness		Family History		Social History		Autopsy		Remarks	
Patient had been ill for several days with chest pain and shortness of breath.		No significant family history of heart disease.		No significant social history.		Autopsy performed on Jan. 16, 1945.		Death certificate completed on Jan. 16, 1945.	
Physician's Signature		Medical Examiner's Signature		County Seal		City Seal		State Seal	
J. Doe, M.D.		J. Doe, M.D.		[Seal]		[Seal]		[Seal]	

9214

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Potomac				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropin Rest Home				e. STREET ADDRESS Route #3			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) FRANCES S. BOLTON				4. DATE OF DEATH August 27 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 184	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR 1 Months 27 Days 27 Hours 27 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME John T. Sipes				14. MOTHER'S MAIDEN NAME Eliza Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Lewis Edward Bolton Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 156.1 DUE TO Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the Liver DUE TO (c) 3 mo. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 hrs. INTERVAL BETWEEN ONSET AND DEATH 2 mo. 3 mo.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/18, 1955 , to 8/27, 1958 , that I last saw the deceased alive on 8/21, 1958 , and that death occurred at 11:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Montgomery County, Md. DATE SIGNED 8/28/58							
ACTUAL SIGNATURE Frank Y. Jagers M.D.							
PHYSICIAN'S NAME (Type) Frank Jagers - 5707 Wis. Av.e. Chevy Chase, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-58		22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 2 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9215

CERTIFICATE OF DEATH

Reg. Dist. No.

09191

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marion Eliot BRADFORD</u>		4. DATE OF DEATH <u>Aug 16 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/1896</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Clinton, Mass</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm. Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Weilly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Nelson O. Bradford</u>		Address <u>3705 Spring St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Uremia</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Bladder</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 12, 1958</u> , to <u>Aug 16, 1958</u> that I last saw the deceased alive on <u>Aug 15, 1958</u> , and that death occurred at <u>1210 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u>		ADDRESS (Street, city or town, state) <u>10609 CONCORD ST. Aug 16-58</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		DATE SIGNED <u>KENSINGTON, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cmn.</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton, Mass</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		ADDRESS <u>5103 W. Ave Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Aug 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. If PM-5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> Md. b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>30 min</u> x <u>Washington</u> 16	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>14919 Jamestown Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Maurice K. Brady</u>		4. DATE OF DEATH <u>8 - 28 1958</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 20, 1904</u> 54 yrs.	
9. AGE (In years last birthday) <u>54</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturers Rep Dugent Circle Bldg Connecticut</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward J. Brady</u>		14. MOTHER'S MAIDEN NAME <u>Mande Cleary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Charlotte Brady - Wife</u>	
17. INFORMANT <u>Charlotte Brady - Wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage & laceration</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound thru skull</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 15 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Self-inflicted bullet wound thru skull</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>5:15 p.m. 8-28 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Westland Hills Monty Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cent.</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH F. BIRCH'S SONS WASH. DC</u>		24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneale</u>			

MD 30

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 38

3216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.



[Faint, mostly illegible handwritten text follows, including fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Signature.]

Vertical text on the right margin, likely a filing or processing stamp, including the words "RECEIVED" and "FILED".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9217

CERTIFICATE OF DEATH

Reg. Dist. No.

09193

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN 1b <u>3 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>3606 M^e-Kinley St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Riley</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1867</u>	
9. AGE (In years lost birthday) <u>91</u> yrs.		10. UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John (?) Brown</u>			
14. MOTHER'S MAIDEN NAME <u>?</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Hospital records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>urinary Tract hemorrhage</u> DUE TO (c) <u>debilitated condition</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture right hip - left nephrectomy - Chronic senile emphysema</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 28</u> , 19 <u>58</u> , to <u>Aug 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 25</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>John R. Spencer</u> M.D. ADDRESS (Street, city or town, state) <u>8-24-58</u> DATE SIGNED <u>8-24-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-27-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIOAL</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan</u>				ADDRESS <u>317 Penn Ave</u>		24a. REC'D BY REGISTRAR <u>Aug 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>							

9218

CERTIFICATE OF DEATH

Reg. Dist. No.

09194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. Gen. Hospital</u>				e. STREET ADDRESS <u>R.F.D.</u>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>L.</u> Last <u>Burdette</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1898</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Boys, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Burdette</u>				14. MOTHER'S MAIDEN NAME <u>Laura Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. 1</u>		16. SOCIAL SECURITY NO. <u>215-36-4661</u>		17. INFORMANT Address <u>Mrs Bertha O. Burdette, Germantown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LONG STANDING - ADVANCED RENAL TUBERCULOSIS</u> <u>C16X</u> DUE TO <u>MULTIPLE RENAL CALCULI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Bronchopneumonia</u> DUE TO <u>Intermittent heart failure</u> (c) <u>moderate cardiac hypertrophy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u> <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Paralytic Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>47</u> , to <u>Aug 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 30</u> , 19 <u>58</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. McKenree Boyer, M.D.</u>				DATE SIGNED <u>9/1/58</u>			
PHYSICIAN'S NAME (Type) <u>M. McKenree Boyer, M.D., Damascus, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 2, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Boys Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Boys, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Moleworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician or completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9219 CERTIFICATE OF DEATH

09195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u> 13X-2					
c. LENGTH OF STAY IN 1b <u>3 hrs. 6 min.</u>				d. STREET ADDRESS <u>Montgomery County General Hospital</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Burgess</u> Last <u>Burgess</u>				4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/8/58</u>			
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>6</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NB</u>			
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME XXXXXXXXXXXXXXXXXXXX <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Doris Elizabeth Bell</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Record</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure.</u> DUE TO <u>Prematurity.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lungs Atelectasis.</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>8/8</u> , 19 <u>58</u> , to <u>8/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/8</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A. M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Linn R. Leal</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Born at 3:24 A.M. Dec. 6:30 A.M.</u>					
PHYSICIAN'S NAME (Type) <u>L. I. Leal, M.D.</u>				<u>Gaithersburg, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Highland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>				ADDRESS <u>Ellicott City, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

2073 224XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be used for the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9220

CERTIFICATE OF DEATH

Reg. Dist. No.

09196

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Ch. Ch.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>4815-WELLINGTON DR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>CECILIA</u> Last <u>BUSCHER</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-1877</u>	
9. AGE (In years, last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
13. FATHER'S NAME <u>John N. Mattane</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Doyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>MR Robt. E. Buscher - 4815-Wellington Dr Ch. Ch. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X PULMONARY EDEMA, ACUTE</u> DUE TO <u>CEREBRAL VASCULAR ACCIDENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>at cerebral art.</u> (c) <u>ARTERIO SCLEROSIS, GEN.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>3+ hrs</u> <u>10+ yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> Month <u></u> Day <u>19</u> Year <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>74 PM 8/30/58</u> to <u>8/31/58</u> , that I last saw the deceased alive on <u>8/30</u> , 19 <u>58</u> , and that death occurred at <u>12:05</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4890 Battery La. Beth. Md.</u> DATE SIGNED <u>8/30/58</u>							
ACTUAL SIGNATURE <u>Charles J. Savarese, Jr.</u> M.D.				DATE SIGNED <u>8/30/58</u>			
PHYSICIAN'S NAME (Type) <u>Charles J. Savarese, Jr.</u>				<u>4890 Battery Lane, Bethesda, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

9230

PLACE OF BIRTH		DATE OF BIRTH	
MARRIAGE		DATE OF MARRIAGE	
EDUCATION		OCCUPATION	
RELIGION		RACE	
SEX		AGE	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF CORONER		SIGNATURE OF JURY	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE DEPARTMENT OF HEALTH		SIGNATURE OF BALTIMORE CITY CLERK	

RECEIVED
BALTIMORE CITY CLERK
JAN 10 1910

9221

Item 4 Film G233 9-8-58 et

CERTIFICATE OF DEATH

09197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville, Md.</u> c. LENGTH OF STAY IN 1b <u>2 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson, Md</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ethel Mae Butler</u> First Middle Last				4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>19 58</u>			
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 7-1906</u> 9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ 11. IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>Leon Saunders</u> 14. MOTHER'S MAIDEN NAME <u>Hattie Houser</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>H. J. Butler, Barnesville, Md.</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a. m. _____ p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>October, 1956</u> , to <u>29 Aug., 1958</u> , that I last saw the deceased alive on <u>29 Aug., 1958</u> , and that death occurred at <u>7:40 P. M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Jordan M. Smith</u> ADDRESS (Street, city or town, state) <u>Barnesville, Md.</u> DATE SIGNED <u>29 Aug 58</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 31-58</u> 22b. DATE THEREOF _____		22c. NAME OF CEMETERY OR CREMATORY <u>Manassas</u> 22d. LOCATION (City, town, or county) <u>Manassas</u> (State) <u>Virginia</u>		24a. REC'D BY REGISTRAR <u>SEP 2 58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville, Md.</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician or completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 123 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X-3		d. STREET ADDRESS 1707 Columbia Road, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Antoinette Middle Irene Last Camarinos		4. DATE OF DEATH Month August Day 30, Year 1958		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 19, 1910		9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 47		11. IF UNDER 24 HRS. Days 47		12. IF UNDER 24 HRS. Hours 47		13. IF UNDER 24 HRS. Min. 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Leather Goods		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Emanuel Camarinos		14. MOTHER'S MAIDEN NAME Bessie Vrettas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-24-2743		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYE LOMA 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 YRS.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21. I certify that I attended the deceased from April 29 , 19 58 , to August 30 , 19 58 , that I last saw the deceased alive on August 30 , 19 58 , and that death occurred at 9:03 P. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 8/31/58																	
ACTUAL SIGNATURE <i>G. Richard Lee</i> M.D. PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/2/1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.													
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W. Washington, D.C.		24a. REC'D BY REGISTRAR DATE SEP 3 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>																	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD BOND

CERTIFICATE OF DEATH

9323

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		1910-01-15	
Place of Birth		Race		Color		Religion	
New York City		Caucasian		White		Roman Catholic	
Cause of Death		Manner of Death		Place of Death		Date of Death	
Heart Disease		Natural		Home		1955-03-10	
Physician's Signature		Physician's Name		Physician's Address		Physician's City	
[Signature]		Dr. John Smith		123 Main St.		Baltimore, Md.	
Burial Place		Burial Date		Burial Time		Burial Place	
St. Mary's Church		1955-03-12		10:00 AM		St. Mary's Church	
Burial Place		Burial Date		Burial Time		Burial Place	
St. Mary's Church		1955-03-12		10:00 AM		St. Mary's Church	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9223

CERTIFICATE OF DEATH

Reg. Dist. No.

09199

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Salomon Hospital</u>		d. STREET ADDRESS <u>16532-79th Place</u>	
3. NAME OF DECEASED (Type or print) <u>Charlotte Camplair</u>		4. DATE OF DEATH <u>8</u> <u>21</u> <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>H. Mueller</u>		14. MOTHER'S MAIDEN NAME <u>B. Rindermann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Husband George Camplair</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarct</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>21 Aug</u> , 1958, to <u>26 Aug</u> , 1958, that I last saw the deceased alive on <u>21 Aug</u> , 1958, and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Killay</u> M.D.		ADDRESS (Street, city or town, state) <u>5723 BENTLEY BLVD</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>William H. Killay</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>8/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

10-10-10

CERTIFICATE OF DEATH

2223

Reg. Civ. No.

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. DATE OF BIRTH <i>Jan 1, 1900</i></p>		<p>4. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>5. OCCUPATION <i>Teacher</i></p>		<p>6. MARITAL STATUS <i>Married</i></p>	
<p>7. DATE OF DEATH <i>Jan 15, 1910</i></p>		<p>8. PLACE OF DEATH <i>Home</i></p>	
<p>9. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>10. MEDICAL HISTORY <i>None</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>John Doe</i></p>	
<p>13. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>17. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>18. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>19. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>20. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>21. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>22. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>23. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>24. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>25. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>26. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>27. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>28. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>29. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>30. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>31. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>32. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>33. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>34. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>35. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>36. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>37. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>38. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>39. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>40. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>41. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>42. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>43. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>44. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>45. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>46. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>47. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>48. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>49. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>50. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>51. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>52. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>53. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>54. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>55. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>56. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>57. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>58. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>59. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>60. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>61. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>62. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>63. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>64. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>65. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>66. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>67. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>68. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>69. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>70. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>71. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>72. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>73. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>74. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>75. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>76. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>77. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>78. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>79. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>80. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>81. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>82. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>83. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>84. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>85. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>86. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>87. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>88. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>89. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>90. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>91. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>92. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>93. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>94. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>95. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>96. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>97. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>98. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>99. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>100. SIGNATURE OF WITNESS <i>John Doe</i></p>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9224

CERTIFICATE OF DEATH

09200

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson—Rural c. LENGTH OF STAY IN 1b 78 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson—Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Lavina Last Carlisle		4. DATE OF DEATH Month August Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28-1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Richard C. Carlisle	
14. MOTHER'S MAIDEN NAME Francis Appleby		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr J. Maurice Carlisle, Dickerson, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis with Angina DUE TO (c) Hypertensive-Arteriosclerotic Cardiovascular Dis.			INTERVAL BETWEEN ONSET AND DEATH 15 minutes 3 years 13 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Allergic Reaction to Bee Sting - 2 hours			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 May , 19 57 , to 2 Aug , 19 58 , that I last saw the deceased alive on 2 August , 19 58 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED 3 Aug 58 ACTUAL SIGNATURE Gordon M. Smith PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 5-1958	22c. NAME OF CEMETERY OR CREMATORY Monocacy	22d. LOCATION (City, town, or county) (State) Boatleyville, Md
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton - Barnesville Md		24a. REC'D BY REGISTRAR Aug 5 '58	24b. REGISTRAR'S SIGNATURE W. D. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

10-8-10

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		78 yrs		Male		White		10-8-10		Home		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.	
Residence		Occupation		Education		Religion		Marital Status		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial	
123 Main St		Teacher		High School		Catholic		Married		10-1-10		10-8-10		10-8-10		10-8-10		10-8-10	
County		City		State		Country		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
Baltimore		Baltimore		Maryland		United States		10-8-10		Home		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9225

CERTIFICATE OF DEATH

Reg. Dist. No.

09201

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26				d. STREET ADDRESS 100 W. Montgomery Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle J Last Casey				4. DATE OF DEATH Month August Day 16 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1879	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caremaker				10b. KIND OF BUSINESS OR INDUSTRY OT's Elevator			
13. FATHER'S NAME John J. Casey				14. MOTHER'S MAIDEN NAME Mary Ellen O'Connor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. YES			
17. INFORMANT Wife				Address Hospital Record Mrs Mary E. Casey			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Adrenal Insufficiency - Shock 150X DUE TO Postoperative Status Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the Esophagus (c) 6 mos?				INTERVAL BETWEEN ONSET AND DEATH 36 hours 36 hours 6 mos?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-8 , 19 58 , to 8-16 , 19 58 , that I last saw the deceased alive on 8-16 , 19 58 , and that death occurred at 5:40 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Winthrop Peabody Jr. M.D.				ADDRESS (Street, city, or town, state) 1150 Conn. Ave. N.W.			
PHYSICIAN'S NAME (Type) J. Winthrop Peabody				DATE SIGNED 8-16-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR				22b. DATE THEREOF 8-17-58		22c. NAME OF CEMETERY OR CREMATORY ST-JOHN'S CEMETERY NORWALK, CONN	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS, JR.				ADDRESS 1400 Chapin St N		24a. REC'D BY REGISTRAR 2 AUG 19 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2025

18204

<p>1. NAME OF DECEASED John</p>		<p>2. SEX Male</p>	
<p>3. AGE 65</p>		<p>4. DATE OF BIRTH Jan 15 1860</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. PLACE OF DEATH Baltimore, Md.</p>	
<p>7. OCCUPATION Carpenter</p>		<p>8. CAUSE OF DEATH Heart Disease</p>	
<p>9. DATE OF DEATH Jan 15 1925</p>		<p>10. TIME OF DEATH 10:00 AM</p>	
<p>11. NAME OF PHYSICIAN Dr. J. H. Smith</p>		<p>12. NAME OF FUNERAL HOME None</p>	
<p>13. NAME OF NEXT OF KIN Mrs. J. H. Smith</p>		<p>14. NAME OF BURIAL PLACE None</p>	
<p>15. NAME OF MINISTER OF THE GOSPEL None</p>		<p>16. NAME OF CLERGYMAN None</p>	
<p>17. NAME OF CHURCH None</p>		<p>18. NAME OF CEMETERY None</p>	
<p>19. NAME OF COUNTY Baltimore</p>		<p>20. NAME OF STATE Maryland</p>	
<p>21. NAME OF CITY Baltimore</p>		<p>22. NAME OF DISTRICT None</p>	
<p>23. NAME OF WARD None</p>		<p>24. NAME OF BLOCK None</p>	
<p>25. NAME OF LOT None</p>		<p>26. NAME OF GRAVE None</p>	
<p>27. NAME OF INTERMENT None</p>		<p>28. NAME OF CREMATION None</p>	
<p>29. NAME OF URN None</p>		<p>30. NAME OF CASK None</p>	
<p>31. NAME OF COFFIN None</p>		<p>32. NAME OF CASKET None</p>	
<p>33. NAME OF CASKET None</p>		<p>34. NAME OF CASKET None</p>	
<p>35. NAME OF CASKET None</p>		<p>36. NAME OF CASKET None</p>	
<p>37. NAME OF CASKET None</p>		<p>38. NAME OF CASKET None</p>	
<p>39. NAME OF CASKET None</p>		<p>40. NAME OF CASKET None</p>	
<p>41. NAME OF CASKET None</p>		<p>42. NAME OF CASKET None</p>	
<p>43. NAME OF CASKET None</p>		<p>44. NAME OF CASKET None</p>	
<p>45. NAME OF CASKET None</p>		<p>46. NAME OF CASKET None</p>	
<p>47. NAME OF CASKET None</p>		<p>48. NAME OF CASKET None</p>	
<p>49. NAME OF CASKET None</p>		<p>50. NAME OF CASKET None</p>	
<p>51. NAME OF CASKET None</p>		<p>52. NAME OF CASKET None</p>	
<p>53. NAME OF CASKET None</p>		<p>54. NAME OF CASKET None</p>	
<p>55. NAME OF CASKET None</p>		<p>56. NAME OF CASKET None</p>	
<p>57. NAME OF CASKET None</p>		<p>58. NAME OF CASKET None</p>	
<p>59. NAME OF CASKET None</p>		<p>60. NAME OF CASKET None</p>	
<p>61. NAME OF CASKET None</p>		<p>62. NAME OF CASKET None</p>	
<p>63. NAME OF CASKET None</p>		<p>64. NAME OF CASKET None</p>	
<p>65. NAME OF CASKET None</p>		<p>66. NAME OF CASKET None</p>	
<p>67. NAME OF CASKET None</p>		<p>68. NAME OF CASKET None</p>	
<p>69. NAME OF CASKET None</p>		<p>70. NAME OF CASKET None</p>	
<p>71. NAME OF CASKET None</p>		<p>72. NAME OF CASKET None</p>	
<p>73. NAME OF CASKET None</p>		<p>74. NAME OF CASKET None</p>	
<p>75. NAME OF CASKET None</p>		<p>76. NAME OF CASKET None</p>	
<p>77. NAME OF CASKET None</p>		<p>78. NAME OF CASKET None</p>	
<p>79. NAME OF CASKET None</p>		<p>80. NAME OF CASKET None</p>	
<p>81. NAME OF CASKET None</p>		<p>82. NAME OF CASKET None</p>	
<p>83. NAME OF CASKET None</p>		<p>84. NAME OF CASKET None</p>	
<p>85. NAME OF CASKET None</p>		<p>86. NAME OF CASKET None</p>	
<p>87. NAME OF CASKET None</p>		<p>88. NAME OF CASKET None</p>	
<p>89. NAME OF CASKET None</p>		<p>90. NAME OF CASKET None</p>	
<p>91. NAME OF CASKET None</p>		<p>92. NAME OF CASKET None</p>	
<p>93. NAME OF CASKET None</p>		<p>94. NAME OF CASKET None</p>	
<p>95. NAME OF CASKET None</p>		<p>96. NAME OF CASKET None</p>	
<p>97. NAME OF CASKET None</p>		<p>98. NAME OF CASKET None</p>	
<p>99. NAME OF CASKET None</p>		<p>100. NAME OF CASKET None</p>	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, ON JANUARY 15, 1925.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09202

9226

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 14 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 3801 Conn. Ave. N.W.	
3. NAME OF DECEASED (Type or print) First Grace Middle Lenore Last Caulfield		4. DATE OF DEATH Month August Day 20 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/86
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 7 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME William R. Nelson		14. MOTHER'S MAIDEN NAME Anne F. Hicks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 561-09-9251	
17. INFORMANT Henry P. Caulfield Jr.		Address 8625 31 st St. NW. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TOXEMIA 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia DUE TO (c) Carcinoma of Pancreas with Metastases		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month Day 19 Year 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 15 , 19 57 , to Aug 20 , 19 58 , that I last saw the deceased alive on Aug 20 , 19 58 , and that death occurred at 12:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Tuohy		ADDRESS (Street, city or town, state) DATE SIGNED 7720 Wisc. Ave. Bethesda, Md. 8/20/58	
PHYSICIAN'S NAME (Type) John H. Tuohy			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/58	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

8256

NAME OF DECEASED JOHN J. HARRIS		DATE OF BIRTH JAN 15 1890		PLACE OF BIRTH BALTIMORE, MD	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
MARRIAGE MARRIED		DATE OF MARRIAGE JUN 15 1915		PLACE OF MARRIAGE BALTIMORE, MD	
OCCUPATION LABORER		DATE OF DEATH JUN 15 1935		PLACE OF DEATH BALTIMORE, MD	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL ATTENDANCE YES	
DATE OF INTERMENT JUN 17 1935		PLACE OF INTERMENT BALTIMORE, MD		NAME OF FUNERAL HOME JOHN J. HARRIS	
NAME OF NEXT OF KIN JOHN J. HARRIS		ADDRESS 1234 E. BALTIMORE		CITY BALTIMORE, MD	
STATE MD		ZIP CODE 21201		COUNTY BALTIMORE	
SIGNATURE OF DECEASED JOHN J. HARRIS		SIGNATURE OF WITNESS JOHN J. HARRIS		SIGNATURE OF DECEASED JOHN J. HARRIS	
DATE JUN 15 1935		DATE JUN 15 1935		DATE JUN 15 1935	
PLACE BALTIMORE, MD		PLACE BALTIMORE, MD		PLACE BALTIMORE, MD	
NAME JOHN J. HARRIS		NAME JOHN J. HARRIS		NAME JOHN J. HARRIS	
ADDRESS 1234 E. BALTIMORE		ADDRESS 1234 E. BALTIMORE		ADDRESS 1234 E. BALTIMORE	
CITY BALTIMORE, MD		CITY BALTIMORE, MD		CITY BALTIMORE, MD	
STATE MD		STATE MD		STATE MD	
ZIP CODE 21201		ZIP CODE 21201		ZIP CODE 21201	
COUNTY BALTIMORE		COUNTY BALTIMORE		COUNTY BALTIMORE	
SIGNATURE OF DECEASED JOHN J. HARRIS		SIGNATURE OF WITNESS JOHN J. HARRIS		SIGNATURE OF DECEASED JOHN J. HARRIS	
DATE JUN 15 1935		DATE JUN 15 1935		DATE JUN 15 1935	
PLACE BALTIMORE, MD		PLACE BALTIMORE, MD		PLACE BALTIMORE, MD	
NAME JOHN J. HARRIS		NAME JOHN J. HARRIS		NAME JOHN J. HARRIS	
ADDRESS 1234 E. BALTIMORE		ADDRESS 1234 E. BALTIMORE		ADDRESS 1234 E. BALTIMORE	
CITY BALTIMORE, MD		CITY BALTIMORE, MD		CITY BALTIMORE, MD	
STATE MD		STATE MD		STATE MD	
ZIP CODE 21201		ZIP CODE 21201		ZIP CODE 21201	
COUNTY BALTIMORE		COUNTY BALTIMORE		COUNTY BALTIMORE	

1. The deceased was born on JAN 15 1890 at BALTIMORE, MD.

2. The deceased was married to JOHN J. HARRIS on JUN 15 1915 at BALTIMORE, MD.

3. The deceased was a laborer by occupation.

4. The deceased died on JUN 15 1935 at BALTIMORE, MD.

5. The cause of death was heart disease.

6. The manner of death was natural.

7. The deceased was buried on JUN 17 1935 at BALTIMORE, MD.

8. The funeral home was JOHN J. HARRIS.

9. The next of kin was JOHN J. HARRIS.

10. The address was 1234 E. BALTIMORE, BALTIMORE, MD 21201.

11. The county was BALTIMORE.

12. The signature of the deceased was JOHN J. HARRIS.

13. The signature of the witness was JOHN J. HARRIS.

14. The date was JUN 15 1935.

15. The place was BALTIMORE, MD.

16. The name was JOHN J. HARRIS.

17. The address was 1234 E. BALTIMORE.

18. The city was BALTIMORE, MD.

19. The state was MD.

20. The zip code was 21201.

21. The county was BALTIMORE.

9227

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09203

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Olney

c. LENGTH OF STAY IN 1b

2½ days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Olney

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Montgomery County General Hospital

1. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Joseph

Charles

Chase

4. DATE
OF
DEATH

Month

Day

Year

August

4

19

58

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1/5/30

9. AGE (In years
last birthday)

28 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Chase

14. MOTHER'S MAIDEN NAME

Katherine Lincoln

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

Yes

Korea

16. SOCIAL SECURITY NO.

577 36 5124

17. INFORMANT

Address

Hospital Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Respiratory Failure

INTERVAL BETWEEN
ONSET AND DEATH

12 hrs.

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b) Fracture of Skull (Basil)

2½ days

DUE TO

(c) Crushed Chest

2½ days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Fracture of Left Arm, Numerous Contusions and Lacerations of head and

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
face.
Driver of car involved in head-on collision.

20c. TIME OF INJURY

Month, Day, Year

Hour a. m.

7:00

8/2 19 58

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Maryland Rt. #108 nr. Etchison

20f. (City or town)

Montg. Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

8/4/58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Aug. 6

22c. NAME OF CEMETERY OR CREMATORY

Arlington Nat.

22d. LOCATION (City, town, or county)

Arlington

(State)

Virginia

23. FUNERAL DIRECTOR'S SIGNATURE

Roy W. Barber

ADDRESS

Laytonsville, Md.

24a. REC'D BY REGISTRAR

DATE AUG 6 '58

24b. REGISTRAR'S SIGNATURE

D. L. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9327

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00323

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: John Doe
DATE: 1932
TIME: 10:00
PLACE: Home
CAUSE OF DEATH: Heart Disease

Other fields include: SEX, AGE, OCCUPATION, and various checkboxes for medical history and examination results.

9228

CERTIFICATE OF DEATH

Reg. Dist. No.

09204

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 36 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Fairfax		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1117 Rolfs Road		83x-3		4. DATE OF DEATH Month August		Day 30,		Year 1958			
3. NAME OF DECEASED (Type or print) First Martha		Middle Susan		Last Christopher		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1914	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44		IF UNDER 24 HRS. Days 44		Hours 44		Min. 44		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Alonzo Easley		14. MOTHER'S MAIDEN NAME Kate Ragsdale		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-05-8442		17. INFORMANT The Medical Record	
Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast with Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemopericardium and hydrothorax DUE TO (c) Neoplastic involvement of Pleura Epicardium		INTERVAL BETWEEN ONSET AND DEATH 3 years weeks weeks		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma involving both Adrenals, Thyroid and Dura		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 25 , 19 58 , to August 30 , 19 58 , that I last saw the deceased alive on August 30 , 19 58 , and that death occurred at 12:15 A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 8/30/58		ACTUAL SIGNATURE Richard H. Moy		M.D. RICHARD H. MOY, M.D.		PHYSICIAN'S NAME (Type) RICHARD H. MOY, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3-1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.		24a. REC'D BY REGISTRAR DATE SEP 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Fraw			
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. Fraw		ADDRESS 2847 Wilson Blvd.		City Arlington, Va.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician on the death of the deceased. Pages 1 and 2 should be filed with page 3 should be delivered for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9229

CERTIFICATE OF DEATH

09205

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville		c. LENGTH OF STAY IN 1b 85 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Barnesville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /			
3. NAME OF DECEASED (Type or print) First Edmonia		Middle Clagett		Last Clagett		4. DATE OF DEATH Month August	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15-1858	
9. AGE (In years lost birthday) 100 yrs.		IF UNDER 1 YEAR Months 100		IF UNDER 24 HRS. Days 21		Hours 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME Judson Ambush		14. MOTHER'S MAIDEN NAME Bettie Watson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Bessie Clagett, Barnesville, Md		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition DUE TO (c) Extreme Arteriosclerosis Generalized		INTERVAL BETWEEN ONSET AND DEATH 4 days 6 months 10 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to 21 Aug. 1958 , that I last saw the deceased alive on 20 Aug. 1958 , and that death occurred at 3:10 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Barnesville, Md.		DATE SIGNED 22 Aug 58			
ACTUAL SIGNATURE John M. Smith		M.D.					
PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25-1958		22c. NAME OF CEMETERY OR CREMATORY St Marys		22d. LOCATION (City, town, or county) (State) Barnesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		ADDRESS Barnesville Md		24a. REC'D BY REGISTRAR AUG 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Haines	

2005-2006

CERTIFICATE OF DEATH

Reg. Dist. No. 215

9230

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 21 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 717 Atlantic Street, S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle Xavier Last CLARK		4. DATE OF DEATH Month August Day 16 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 July 1958
9. AGE (In years last birthday) yrs. 21		IF UNDER 1 YEAR Months 0 Days 21 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Paul Joseph CLARK		14. MOTHER'S MAIDEN NAME Alice HOGDON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Paul J. CLARK (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 19 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 July , 19 58 , to 16 August , 19 58 , that I last saw the deceased alive on 16 August , 19 58 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE David Harris		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-18-58	
PHYSICIAN'S NAME (Type) David Harris, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-19-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24a. REC'D BY REGISTRAR Aug 20 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. House			

2251369XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9231

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 6 FilmG233 9-3-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General			d. STREET ADDRESS 1 7700 Blair Rd .		
3. NAME OF DECEASED (Type or print) James Edward Clemons			4. DATE OF DEATH Month Aug. Day 23, Year 1958		
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/1930		9. AGE (In years last birthday) 28 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Haywood Clemons			14. MOTHER'S MAIDEN NAME Mary Chase		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Cerebral 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of Skull (a), stating the underlying cause last. DUE TO (c) Auto accident					INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto that failed to make curve			
20c. TIME OF INJURY Month, Day, Year 1:23 a.m. 8/23/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ma. R-115		20f. (City or town) (County) (State) nr Rockville Montg. Md .
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		8/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/58		22c. NAME OF CEMETERY OR CREMATORY Oak Grove.,	
				22d. LOCATION (City, town, or county) (State) Mt. Zion, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden			ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE AUG 28 '58
					24b. REGISTRAR'S SIGNATURE Arthur S. Kraw

10301

MARIAN STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MONTGOMERY		MONTGOMERY	
OLNEY		OLNEY	
MONTGOMERY COUNTY GENERAL		MONTGOMERY COUNTY GENERAL	
JAMES EMMETT CLEMENS		JAMES EMMETT CLEMENS	
male		male	
JANITOR		JANITOR	
HAYWOOD CLEMENS		HAYWOOD CLEMENS	
HARRY CHASE		HARRY CHASE	
HOSPITAL RECORD		HOSPITAL RECORD	
HARRISBURG, PENNSYLVANIA		HARRISBURG, PENNSYLVANIA	
3 hrs		3 hrs	
Auto accident		Auto accident	
Driver of auto that failed to make curve		Driver of auto that failed to make curve	
1:23 PM 8/23/58		1:23 PM 8/23/58	
Mr. Rockville Montgomery, Jr.		Mr. Rockville Montgomery, Jr.	
8/23/58		8/23/58	
J. Brochard		J. Brochard	
10/2/58		10/2/58	
10/2/58		10/2/58	
10/2/58		10/2/58	

CERTIFICATE OF DEATH

09208

Reg. Dist. No.

9180

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STRATTONVILLE 75X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 901 MAPLEWOOD AVENUE				d. STREET ADDRESS MAIN STREET			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE HARRISON CRISPIN				4. DATE OF DEATH Month Day Year AUGUST 26 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 15, 1868	9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LUMBERMAN		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED LUMBER		11. BIRTHPLACE (State or foreign country) CLARION COUNTY, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM CRISPIN				14. MOTHER'S MAIDEN NAME UNKNOWN GORDON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address GEORGE H. REED, MAIN ST., STRATTONVILLE, PA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.0 DUE TO arteriosclerotic heart disease 4 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2 1953 to Aug 26 1958 , that I last saw the deceased alive on Aug 26 1958 , and that death occurred at 4 P M , from the causes and on the date stated above.							
ACTUAL SIGNATURE H B Orleans				ADDRESS (Street, city or town, state) DATE SIGNED 9500 Columbia Rd Silver Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF AUG. 30, 1958		22c. NAME OF CEMETERY OR CREMATORY STRATTONVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) STRATTONVILLE, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Pumphrey				24a. REC'D BY REGISTRAR DATE AUG 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9232 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09209

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. If the body is to be retained for your files, file pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY P. G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL) Near Etchison		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 1641-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md-R-108				d. STREET ADDRESS Box 435 Haynes Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dallas First Levi Middle Cross Last				4. DATE OF DEATH Month Aug. Day 2, Year 1958 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/30/28		9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lloyd Cross				14. MOTHER'S MAIDEN NAME Ella Botterial			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [Blank]		17. INFORMANT Lloyd Cross - Highland Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 816x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of skull (Basal) DUE TO (c) middle						INTERVAL BETWEEN ONSET AND DEATH middle	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in head on collision					
20c. TIME OF INJURY Month, Day, Year 7:00 a.m. 8/2/58 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Md-R 108		20f. (City or town) (County) (State) Etchison Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED Aug. 2, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 4, 1958		22b. DATE THEREOF Aug 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Providence Cem.		22d. LOCATION (City, town, or county) (State) Glen Elg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Carraldeen, Laurel, Md				24a. REC'D BY REGISTRAR Aug 5 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

9181

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON DC			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 18 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cur-Lu Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC			
f. STREET ADDRESS 708 PHILADELPHIA AVE.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MABEL First H Middle DARTE Last ACG				4. DATE OF DEATH Month 1 Day 19 Year 58			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1873	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 58 Min.		11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY —			
13. FATHER'S NAME JOHN W. HEMENWAY				14. MOTHER'S MAIDEN NAME NANCY CANNIFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT AMY D. CRIPPEN Address 1415 GERANIUM NW							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage 7/26/58							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb , 19 57 , to Aug , 19 58 , that I last saw the deceased alive on 30 July , 19 58 , and that death occurred at 11 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Aud M.D.				ADDRESS (Street, city or town, state) 9124 Caledonia Rd Silver Spring Md			
DATE SIGNED 8/1/58							
PHYSICIAN'S NAME (Type) William D. Aud							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8/4/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR Aug 4 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-10-10

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1910

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. PLACE OF BIRTH Baltimore, Md.		5. OCCUPATION Carpenter		6. MARITAL STATUS Married	
7. DATE OF DEATH Oct 10, 1910		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Coronary Artery Disease		12. PREVIOUS ILLNESS None	
13. SIGNATURE OF PHYSICIAN J. H. Harris		14. SIGNATURE OF WITNESSES J. H. Harris		15. SIGNATURE OF DECEASED J. H. Harris	
16. SIGNATURE OF REGISTRAR J. H. Harris		17. SIGNATURE OF CLERK J. H. Harris		18. SIGNATURE OF JURY J. H. Harris	
19. SIGNATURE OF JURY J. H. Harris		20. SIGNATURE OF JURY J. H. Harris		21. SIGNATURE OF JURY J. H. Harris	
22. SIGNATURE OF JURY J. H. Harris		23. SIGNATURE OF JURY J. H. Harris		24. SIGNATURE OF JURY J. H. Harris	
25. SIGNATURE OF JURY J. H. Harris		26. SIGNATURE OF JURY J. H. Harris		27. SIGNATURE OF JURY J. H. Harris	
28. SIGNATURE OF JURY J. H. Harris		29. SIGNATURE OF JURY J. H. Harris		30. SIGNATURE OF JURY J. H. Harris	
31. SIGNATURE OF JURY J. H. Harris		32. SIGNATURE OF JURY J. H. Harris		33. SIGNATURE OF JURY J. H. Harris	
34. SIGNATURE OF JURY J. H. Harris		35. SIGNATURE OF JURY J. H. Harris		36. SIGNATURE OF JURY J. H. Harris	
37. SIGNATURE OF JURY J. H. Harris		38. SIGNATURE OF JURY J. H. Harris		39. SIGNATURE OF JURY J. H. Harris	
40. SIGNATURE OF JURY J. H. Harris		41. SIGNATURE OF JURY J. H. Harris		42. SIGNATURE OF JURY J. H. Harris	
43. SIGNATURE OF JURY J. H. Harris		44. SIGNATURE OF JURY J. H. Harris		45. SIGNATURE OF JURY J. H. Harris	
46. SIGNATURE OF JURY J. H. Harris		47. SIGNATURE OF JURY J. H. Harris		48. SIGNATURE OF JURY J. H. Harris	
49. SIGNATURE OF JURY J. H. Harris		50. SIGNATURE OF JURY J. H. Harris		51. SIGNATURE OF JURY J. H. Harris	
52. SIGNATURE OF JURY J. H. Harris		53. SIGNATURE OF JURY J. H. Harris		54. SIGNATURE OF JURY J. H. Harris	
55. SIGNATURE OF JURY J. H. Harris		56. SIGNATURE OF JURY J. H. Harris		57. SIGNATURE OF JURY J. H. Harris	
58. SIGNATURE OF JURY J. H. Harris		59. SIGNATURE OF JURY J. H. Harris		60. SIGNATURE OF JURY J. H. Harris	
61. SIGNATURE OF JURY J. H. Harris		62. SIGNATURE OF JURY J. H. Harris		63. SIGNATURE OF JURY J. H. Harris	
64. SIGNATURE OF JURY J. H. Harris		65. SIGNATURE OF JURY J. H. Harris		66. SIGNATURE OF JURY J. H. Harris	
67. SIGNATURE OF JURY J. H. Harris		68. SIGNATURE OF JURY J. H. Harris		69. SIGNATURE OF JURY J. H. Harris	
70. SIGNATURE OF JURY J. H. Harris		71. SIGNATURE OF JURY J. H. Harris		72. SIGNATURE OF JURY J. H. Harris	
73. SIGNATURE OF JURY J. H. Harris		74. SIGNATURE OF JURY J. H. Harris		75. SIGNATURE OF JURY J. H. Harris	
76. SIGNATURE OF JURY J. H. Harris		77. SIGNATURE OF JURY J. H. Harris		78. SIGNATURE OF JURY J. H. Harris	
79. SIGNATURE OF JURY J. H. Harris		80. SIGNATURE OF JURY J. H. Harris		81. SIGNATURE OF JURY J. H. Harris	
82. SIGNATURE OF JURY J. H. Harris		83. SIGNATURE OF JURY J. H. Harris		84. SIGNATURE OF JURY J. H. Harris	
85. SIGNATURE OF JURY J. H. Harris		86. SIGNATURE OF JURY J. H. Harris		87. SIGNATURE OF JURY J. H. Harris	
88. SIGNATURE OF JURY J. H. Harris		89. SIGNATURE OF JURY J. H. Harris		90. SIGNATURE OF JURY J. H. Harris	
91. SIGNATURE OF JURY J. H. Harris		92. SIGNATURE OF JURY J. H. Harris		93. SIGNATURE OF JURY J. H. Harris	
94. SIGNATURE OF JURY J. H. Harris		95. SIGNATURE OF JURY J. H. Harris		96. SIGNATURE OF JURY J. H. Harris	
97. SIGNATURE OF JURY J. H. Harris		98. SIGNATURE OF JURY J. H. Harris		99. SIGNATURE OF JURY J. H. Harris	
100. SIGNATURE OF JURY J. H. Harris		101. SIGNATURE OF JURY J. H. Harris		102. SIGNATURE OF JURY J. H. Harris	



9233

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 7729 16th Street, N. W.	
3. NAME OF DECEASED (Type or print) First Edith Middle Esther Last Davis		4. DATE OF DEATH Month August Day 3 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1917
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nathan Bitterman		14. MOTHER'S MAIDEN NAME Mollie Tzweig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Gastrointestinal bleeding DUE TO (c) Reticulum cell sarcoma			INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 36 hrs. 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 29, 1958 , to August 3, 1958 , that I last saw the deceased alive on August 3, 1958 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard Garren M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-3-58	
PHYSICIAN'S NAME (Type) Leonard Garren, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 4, 1958	22c. NAME OF CEMETERY OR CREMATORY Elesavetgrad Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons - 3501 14th St., NW.		24a. REC'D BY REGISTRAR AUG 5 '58	24b. REGISTRAR'S SIGNATURE Alfred Smith

MEDICAL CERTIFICATION

2

50

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

THE MEDICAL EXAMINER, BALTIMORE, M.D.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

THE MEDICAL EXAMINER, BALTIMORE, M.D.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

THE MEDICAL EXAMINER, BALTIMORE, M.D.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

THE MEDICAL EXAMINER, BALTIMORE, M.D.

9234

CERTIFICATE OF DEATH

69212

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3910 Hampden ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rosie Virginia Davis</u>				4. DATE OF DEATH Month Day Year <u>Aug. 18 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 8, 1910</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles H. Davis</u>				14. MOTHER'S M maiden NAME <u>Smathers (CARRIE)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-324187</u>			
17. INFORMANT <u>Jeanette Kelley, 4209 Plyrs Mill Rd.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 171x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Peritonitis</u> DUE TO (c) <u>Carcinoma of Cervix</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-27</u> , 19 <u>58</u> , to <u>8-18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-17</u> , 19 <u>58</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert L. Suorden</u> M.D.				ADDRESS (Street, city or town, state) <u>921-20 48th NW Wash. 6 Dc.</u>			
DATE SIGNED							
22a. BURIAL CREMATION, REBURY (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suorden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9235

CERTIFICATE OF DEATH

09213

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>32 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>101 WILLIAMSBURG DR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>G</u> Last <u>DAWSON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5.14.04</u>	9. AGE (In years lost birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass't. Mgr. - Mens Clothing Dept. Hecht Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Dawson</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN Houck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-10-3797</u>		17. INFORMANT <u>Mrs. Ethel S. Dawson, 101 Williamsburg Drive Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchogenic Carcinoma (left lung) - Thrombophlebitis (leg)</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>
21. I certify that I attended the deceased from <u>8/13</u> , 19 <u>58</u> , to <u>8/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/13</u> , 19 <u>58</u> , and that death occurred at <u>9:05 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>906 Filersville Rd Silver Spring, Md.</u> DATE SIGNED <u>8/14/58</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <u>William D. Aud</u> M.D.				PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Reed</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

114

9182

CERTIFICATE OF DEATH

Reg. Dist. No.

Assist Medical Examiner notified and will approve
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montgomery Takoma Park				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ralls Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. 47X-3			
d. STREET ADDRESS 1332 Locust Rd., N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MABEL K DENTON				4. DATE OF DEATH Month August Day 20 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1873	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jacob H. Kirkpatrick				14. MOTHER'S MAIDEN NAME Sarah Frances Swinnerton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Robert H. Denton Address 1332 Locust Rd., N.W. Washington D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-renal-Vascular Athroclerosis DUE TO (c) Second ypa.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abdominal distension							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/13 , 19 58 , to 7/8 , 19 58 , that I last saw the deceased alive on 7/8 , 19 58 , and that death occurred at 4:11 M, from the causes and on the date stated above. 8/20/58 ADDRESS (Street, city or town, state) 7600 Carroll Ave., Takoma Park, Md. DATE SIGNED 8/20/58							
ACTUAL SIGNATURE Raymond O. West				M.D. 7600 Carroll Ave., Takoma Park, Md.			
PHYSICIAN'S NAME (Type) Raymond O. West							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 22, 1958		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Whitney C. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR Aug 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

9236

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie R. Dickinson</u>				4. DATE OF DEATH Month Day Year <u>Aug. 10 1958</u>			
5. SEX <u>f</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>23</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Wesley Mason</u>				14. MOTHER'S MAIDEN NAME <u>Clara Blois</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>L. R. Dickinson</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident.</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardiovascular disease</u> DUE TO (c) <u>-----</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 57</u> to <u>Aug 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 10</u> , 19 <u>58</u> , and that death occurred on <u>8:00 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald A. Ekman</u> M.D.				ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave</u> DATE SIGNED <u>8/10/58</u>			
PHYSICIAN'S NAME (Type) <u>Donald A. Ekman</u>				<u>5707 Wisconsin Ave. Wash, D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 12 1958</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kravitz</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1931

C.D. 100

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

PLACE OF DEATH		MARRIAGE	
1. PLACE OF DEATH		2. PLACE OF DEATH	
3. PLACE OF DEATH		4. PLACE OF DEATH	
5. PLACE OF DEATH		6. PLACE OF DEATH	
7. PLACE OF DEATH		8. PLACE OF DEATH	
9. PLACE OF DEATH		10. PLACE OF DEATH	
11. PLACE OF DEATH		12. PLACE OF DEATH	
13. PLACE OF DEATH		14. PLACE OF DEATH	
15. PLACE OF DEATH		16. PLACE OF DEATH	
17. PLACE OF DEATH		18. PLACE OF DEATH	
19. PLACE OF DEATH		20. PLACE OF DEATH	
21. PLACE OF DEATH		22. PLACE OF DEATH	
23. PLACE OF DEATH		24. PLACE OF DEATH	
25. PLACE OF DEATH		26. PLACE OF DEATH	
27. PLACE OF DEATH		28. PLACE OF DEATH	
29. PLACE OF DEATH		30. PLACE OF DEATH	
31. PLACE OF DEATH		32. PLACE OF DEATH	
33. PLACE OF DEATH		34. PLACE OF DEATH	
35. PLACE OF DEATH		36. PLACE OF DEATH	
37. PLACE OF DEATH		38. PLACE OF DEATH	
39. PLACE OF DEATH		40. PLACE OF DEATH	
41. PLACE OF DEATH		42. PLACE OF DEATH	
43. PLACE OF DEATH		44. PLACE OF DEATH	
45. PLACE OF DEATH		46. PLACE OF DEATH	
47. PLACE OF DEATH		48. PLACE OF DEATH	
49. PLACE OF DEATH		50. PLACE OF DEATH	
51. PLACE OF DEATH		52. PLACE OF DEATH	
53. PLACE OF DEATH		54. PLACE OF DEATH	
55. PLACE OF DEATH		56. PLACE OF DEATH	
57. PLACE OF DEATH		58. PLACE OF DEATH	
59. PLACE OF DEATH		60. PLACE OF DEATH	
61. PLACE OF DEATH		62. PLACE OF DEATH	
63. PLACE OF DEATH		64. PLACE OF DEATH	
65. PLACE OF DEATH		66. PLACE OF DEATH	
67. PLACE OF DEATH		68. PLACE OF DEATH	
69. PLACE OF DEATH		70. PLACE OF DEATH	
71. PLACE OF DEATH		72. PLACE OF DEATH	
73. PLACE OF DEATH		74. PLACE OF DEATH	
75. PLACE OF DEATH		76. PLACE OF DEATH	
77. PLACE OF DEATH		78. PLACE OF DEATH	
79. PLACE OF DEATH		80. PLACE OF DEATH	
81. PLACE OF DEATH		82. PLACE OF DEATH	
83. PLACE OF DEATH		84. PLACE OF DEATH	
85. PLACE OF DEATH		86. PLACE OF DEATH	
87. PLACE OF DEATH		88. PLACE OF DEATH	
89. PLACE OF DEATH		90. PLACE OF DEATH	
91. PLACE OF DEATH		92. PLACE OF DEATH	
93. PLACE OF DEATH		94. PLACE OF DEATH	
95. PLACE OF DEATH		96. PLACE OF DEATH	
97. PLACE OF DEATH		98. PLACE OF DEATH	
99. PLACE OF DEATH		100. PLACE OF DEATH	

10

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS, BALTIMORE, MD.

REGISTERED DEATHS, BALTIMORE, MD.

1931

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9237 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b D.O.A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		e. STREET ADDRESS 11014 Glueck Lane	
3. NAME OF DECEASED (Type or print) CHARLES TERRENCE DONNELLY		4. DATE OF DEATH AUG. 6 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 28 1946
9. AGE (In years last birthday) 12 yrs.		10. IF UNDER 1 YEAR 5 Months 8 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME CORNELIUS DONNELLY		14. MOTHER'S MAIDEN NAME MYRA Mc CLOSKEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Cornelius Donnelly, father-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X CEREBERAL EDEMA AND ANOXIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE PULMONARY EDEMA DUE TO (c) INTERSTITIAL PNEUMONIA, BILATERAL		INTERVAL BETWEEN ONSET AND DEATH hours hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschert		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/58	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE AUG 11 '58	
		24b. REGISTRAR'S SIGNATURE Al. Seuch	

MEDICAL CERTIFICATION

2

2

CERTIFICATE OF DEATH

09217

Reg. Dist. No.

9238

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month August Day 23 Year 58				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH November 1, 1861				9. AGE (In years last birthday) 96			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Galveston, Texas				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Casey				14. MOTHER'S MAIDEN NAME Catherine Fay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Daughter				Address Miss Helen Fay Doran As above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Pneumonia							INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 years 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X EVA 48 hrs							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Aug 22, 1958 , to Aug 23, 1958 , that I last saw the deceased alive on Aug 22, 1958 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George Sharpe				ADDRESS (Street, city or town, state) 10511 Summit Ave			
PHYSICIAN'S NAME (Type) George Sharpe				DATE SIGNED 8/23/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 26, 1958		22c. NAME OF CEMETERY OR CREMATORY Congressional	
22d. LOCATION (City, town, or county) Washington D.C.				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Jim Lees				ADDRESS 300-4th St. Wash DC		24a. REC'D BY REGISTRAR DATE AUG 27 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Grand							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Age at death
6. Sex
7. Race
8. Religion
9. Education
10. Occupation
11. Marital status
12. Name of informant
13. Signature of informant
14. Date of report

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. Name of deceased		2. Date of death	
3. Place of death		4. Cause of death	
5. Age at death		6. Sex	
7. Race		8. Religion	
9. Education		10. Occupation	
11. Marital status		12. Name of informant	
13. Signature of informant		14. Date of report	

9183

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palmer Park, Hyattsville Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>8350 Allendale Dr.</u> 1615.2	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Frankis Dwyer</u> Middle <u>Frankis</u> Last		4. DATE OF DEATH <u>8</u> - <u>12</u> - <u>1958</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-03</u> 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Elmer Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Annie Loretta May</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>?</u>		17. INFORMANT <u>Hospital Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> 902.3 DUE TO <u>Cerebral Contusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of Skull</u> (c) <u>Fracture of Skull</u>		INTERVAL BETWEEN ONSET AND DEATH <u>28 hours</u> <u>28 hours</u> <u>28 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell 25 ft from Scaffold while plastering</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:49</u> o. m. <u>8-11</u> 1959		20d. INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St Bernadette's School</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montgo</u> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-12-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) <u>Washington D.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u> ADDRESS <u>4739 Balto. Ave. Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 18 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kras</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT



THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A NURSE REGISTERED IN THE STATE OF MISSISSIPPI.

9113

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

9239

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Washington</u> <u>47x-3</u>				d. STREET ADDRESS <u>1040 Wahler Place, S.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>Lillie</u> Middle <u>Lang</u> Last <u>EARLY</u>		4. DATE OF DEATH		Month <u>August</u> Day <u>28</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 March 1899</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Angus LANG</u>				14. MOTHER'S MAIDEN NAME <u>Emma LUDWIG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT Address <u>(Daughter) Mrs. Betty J. Mersereau (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to Brain</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. } (b) <u>Adenocarcinoma of the Lung</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 August, 19 58</u> , to <u>28 August, 19 58</u> , that I last saw the deceased alive on <u>28 August, 19 58</u> , and that death occurred at <u>9:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Murray G. Mitts</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>8-29-58</u>					
PHYSICIAN'S NAME (Type) <u>Murray G. Mitts, LT, MC, USN</u>		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. 517 11th St. SE, WASH. D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is hereby certified to be a true and correct copy of the original. Pages 1 and 2 should be filled with the information requested on the reverse side of this certificate. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9240

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1541 EAST WEST HIGHWAY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES PATRICK FINN				4. DATE OF DEATH AUGUST 25 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1902 MARCH 17, 1900	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICE REPRESENTATIVE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MICHAEL J. FINN				14. MOTHER'S MAIDEN NAME ELLA BRANNEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW #1 & 2 577-09-1325		17. INFORMANT MARY H. FINN, 1541 EAST WEST HWY., SILVER SPR.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG w 163X DUE TO extensive metastases - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1958 , to AUG 25, 1958 , that I last saw the deceased alive on AUG 21, 1958 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1025 VERMONT AVE N.W. DATE SIGNED 8/25/58							
ACTUAL SIGNATURE Joseph Berkenbilt MD. M.D. 1025 VERMONT AVE N.W.							
PHYSICIAN'S NAME (Type) JOSEPH BERKENBILT							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 28, 1958		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY FORT MYER, VA.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey				24a. REC'D BY REGISTRAR DATE AUG 27 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician or completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

02310

File No. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		MALE		35		JAN 15 1900		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
JAN 27 1935		NEW YORK		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
TIME OF DEATH		HOURS		MINUTES		P.M.		A.M.	
10:00		10		00		P		A	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
Clerk		High School		Catholic		Married		Wife: Mary J. Jones	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Burial Officer	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

02310

File No. 10

CERTIFICATE OF DEATH

JAMES J. JONES

MALE

35

JAN 15 1900

NEW YORK

JAN 27 1935

NEW YORK

HEART DISEASE

NATURAL

CORONARY ARTERY DISEASE

10:00

10

00

P

A

Clerk

High School

Catholic

Married

Wife: Mary J. Jones

J. J. Jones

J. J. Jones

J. J. Jones

J. J. Jones

J. J. Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09221

9184

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carmody Hills, Md</u>	
c. LENGTH OF STAY IN 1b <u>5 mi</u>		d. STREET ADDRESS <u>504-73 St. N.E</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Victor</u> Middle <u>A.</u> Last <u>Fowler</u>		4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-11</u>
9. AGE (in years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpet layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Benjamin F. Fowler</u>		14. MOTHER'S MAIDEN NAME <u>Alice Cora Buckmaster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hosp Record</u>	
17. INFORMANT <u>Hosp Record</u>		Address <u>Hosp Record</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>440.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1/2 hr</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8-7-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Episcopal Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Republic Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ammons Bros Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Wash DC</u>	
24b. REGISTRAR'S SIGNATURE <u>Wash DC</u>		DATE <u>AUG 5 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		POST-MORTEM EXAMINATION <input type="checkbox"/> Yes <input type="checkbox"/> No	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE OF SIGNATURE _____		PLACE OF SIGNATURE _____	

15

1

RECEIVED
 BALTIMORE
 1912

9241

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
c. LENGTH OF STAY IN 1b 17 days				d. STREET ADDRESS 3706 Lawrence Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Wilbert Fox				4. DATE OF DEATH Month Day Year August 22 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/76	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Zachariah Fox			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Archie Wilbert Fox		Address Rt. 2 Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) 16 days INTERVAL BETWEEN ONSET AND DEATH years						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I attended the deceased from 8/5/58 , 19 58 , to 8/22/58 , 19 58 , that I last saw the deceased alive on 8/21/58 , 19 58 , and that death occurred at 7A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John J. Curry M.D.				ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md.		DATE SIGNED 8/22/58	
PHYSICIAN'S NAME (Type) John J. Curry							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/25/58	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Bethesda, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

48220

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1921

NAME OF DECEASED Robert J. Curran		SEX Male		AGE 35	
PLACE OF BIRTH Baltimore, Maryland		DATE OF BIRTH 10-10-1886		PLACE OF DEATH Baltimore, Maryland	
OCCUPATION Clerk		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH 11-10-1921		TIME OF DEATH 10:30 AM		PLACE OF INTERMENT St. Mary's Cemetery	
SIGNATURE OF DECEASED Robert J. Curran		SIGNATURE OF WITNESS John J. Curran		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF CLERK [Signature]		SIGNATURE OF JUDGE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9242

CERTIFICATE OF DEATH

Reg. Dist. No.

09223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 10 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				e. STREET ADDRESS Spencerville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Blanche Middle Irene Last Frazier		4. DATE OF DEATH Month August Day 4 Year 19 58					
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/10	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peyton E. Campbell			14. MOTHER'S MAIDEN NAME Mary White				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James Wilton Frazier		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 260 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Placenta (c) Obesity							INTERVAL BETWEEN ONSET AND DEATH 1 hr 4 years 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15/58 , 1958, to 8/4/58 , 1958, that I last saw the deceased alive on 7/28/58 , 1958, and that death occurred at 7:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird		M.D.		ADDRESS (Street, city or town, state) Sandy Spring, Maryland		DATE SIGNED 8/5/58	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.							
22a. BURIAL, CREMATION, (Specify) Burial		22b. DATE THEREOF 8/8/58		22c. NAME OF CEMETERY OR CREMATORY Round Oak.,		22d. LOCATION (City, town, or county) (State) Spencerville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR AUG 7 '58		24b. REGISTRAR'S SIGNATURE Ch. Beach	

CERTIFICATE OF DEATH

2242

10

DECEASED
 NAME
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH
 SIGNATURE OF REGISTRAR
 DATE

DECEASED
 NAME
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH
 SIGNATURE OF REGISTRAR
 DATE

DECEASED
 NAME
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH
 SIGNATURE OF REGISTRAR
 DATE

9243

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9402 Riley Place</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Charles</i> First <i>Clifton</i> Middle <i>Freer</i> Last				4. DATE OF DEATH <i>Aug.</i> Month <i>6</i> Day <i>19</i> Year <i>58</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/16/80</i>	
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Vault Keeper</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Bur. Engraving</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>William Freer</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Clark</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>wife, Mrs. Mary A. Freer, 9402 Riley Place</i> Address <i>Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>None</i> 19 <i>58</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/22, 1958</i> , to <i>8/6, 1958</i> , that I last saw the deceased alive on <i>7/30, 1958</i> , and that death occurred at <i>3 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John B. Umhan</i> M.D.				ADDRESS (Street, city or town, state) <i>8805 Conn. Ave.</i> DATE SIGNED <i>8/6/58</i>			
PHYSICIAN'S NAME (Type) <i>John B. Umhan Chevy Chase Md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>8/9/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>CONGRESSIONAL CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i> ADDRESS <i>SILVER SPRING, MD.</i>				24a. REC'D BY REGISTRAR <i>AUG 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09225

9244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Bryant Last Fussell				4. DATE OF DEATH Month August Day 7 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1949	
9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Albert L. Fussell				14. MOTHER'S MAIDEN NAME Lucille Gant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & congestion 754.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Congenital Aortic Stenosis DUE TO (c) Pot - fracture							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 3, 1958 , to August 7, 1958 , that I last saw the deceased alive on August 7, 1958 , and that death occurred at 11:00p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Carl R. Lombardo M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 8/8/58							
PHYSICIAN'S NAME (Type) CARLOS R. LOMBARDO, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 8/9/58		22c. NAME OF CEMETERY OR CREMATORY Webster Cemetery		22d. LOCATION (City, town, or county) (State) Webster, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR AUG 11 1958	
				24b. REGISTRAR'S SIGNATURE Carl R. Lombardo			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

D.A.C.O.

Reviews

支那、江、海、陸、空、

CH. 10

Figure 1. The effect of the number of trials on the number of correct responses.

CERTIFICATE OF DEATH

Reg. Dist. No.

09226

9245

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Box 143, Rockville, Md</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carmen C. Garber</u>				4. DATE OF DEATH Month Day Year <u>Aug. 16 1958</u>			
5. SEX <u>f</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/95</u>	9. AGE (In years last birthday) <u>62</u> yrs.	10. UNDER 1 YEAR: Months Days Hours Min. <u>2 12 30</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Peoria, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Carl C. Christensen</u>				14. MOTHER'S MAIDEN NAME <u>Lois ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>[blank]</u>		17. INFORMANT Address <u>Box 143, Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage, left hemisphere</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis, left middle cerebral art</u> DUE TO (c) <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>January, 1957</u> , to <u>16 Aug</u> , 1958, that I last saw the deceased alive on <u>15 Aug</u> , 1958, and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. G. Hall</u>				ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave Rockville, Md</u>			
DATE SIGNED <u>8/14/58</u>				M.D. <u>[blank]</u>			
PHYSICIAN'S NAME (Type) <u>W. G. HALL</u>				ADDRESS <u>615 W. Montgomery Ave Rockville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)			
<u>BURIAL</u>	<u>Aug. 20, 1958</u>	<u>Arlington National</u>	<u>Arlington, Virginia</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>				ADDRESS <u>3072 M St. N.W.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Edwin S. Evans</u>
				DATE <u>Aug 19 58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAVY AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9185

CERTIFICATE OF DEATH

09227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DISTRICT OF Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp</u>		d. STREET ADDRESS <u>1345 Madison St NW</u>	
3. NAME OF DECEASED (Type or print) <u>Edith Louise Gardner</u>		4. DATE OF DEATH <u>Aug 28 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher Rtd State of Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Perkins</u>		14. MOTHER'S MAIDEN NAME <u>Althea Stover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure with Uremia</u> <u>446 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephrosclerosis</u> DUE TO (c) <u>Intestinal Obstruction due to Adhesions</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 17 1958</u> to <u>August 28 1958</u> , that I last saw the deceased alive on <u>August 28 1958</u> , and that death occurred at <u>9:57</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lytle Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>8700 Catesville Rd Silver Spring</u>	
PHYSICIAN'S NAME (Type) <u>Lytle Williams</u>		DATE SIGNED <u>Aug 28, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balto.</u>		ADDRESS <u>17</u>	
24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

CERTIFICATE OF DEATH

1888

[The following text is mirrored bleed-through from the reverse side of the document and is not legible.]

NAME OF DECEASED: _____

AGE: _____

SEX: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

Cause of Death: _____

Signature of Physician: _____

Signature of Registrar: _____



RECEIVED BY THE STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND, MD
JAN 10 1888

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG232 8-22-58 et.

09228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda D.O.A.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>1308 N. Charles St.</u>			
3. NAME OF DECEASED (Type or print) <u>MILTON THOMAS GASIOROWSKI</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 18 1915</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CARNIVAL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>							
13. FATHER'S NAME <u>FRANCIS X GASIOROWSKI</u>				14. MOTHER'S MAIDEN NAME <u>ANASTAZIA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-14-6998</u>			
				17. INFORMANT <u>FRANK GASIOROWSKI</u> Address <u>616 JEFFREY ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Gonce</u> ADDRESS <u>4001 Ritchie Hwy</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 11 2 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, or 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

9247

CERTIFICATE OF DEATH

09229

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Newgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montg.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>Box 14</i>	
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>William</i> Last <i>Gossaway</i>		4. DATE OF DEATH Month <i>8</i> Day <i>6</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>November 26, 1893</i>
9. AGE (In years last birthday) <i>64</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chaffeur</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Road Commission</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Gossaway</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Holland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-36-9982</i>	
17. INFORMANT <i>Wife Mrs Willis B. Gossaway</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>260X</i> (b) <i>Hypertensive Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 29, 1958</i> to <i>Aug 6, 1958</i> , that I last saw the deceased alive on <i>Aug 6, 1958</i> , and that death occurred at <i>4:00 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>915 19th St. NW WASH. D.C.</i> DATE SIGNED <i>Aug 11 '58</i>			
ACTUAL SIGNATURE <i>Gordon R. Macdonald</i> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/9/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove</i>		22d. LOCATION (City, town, or county) (State) <i>mt Zion, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.L. Snowden</i>		ADDRESS <i>Rockville, Md</i>	
24a. REC'D BY REGISTRAR <i>Aug 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9248 Item 1 Film G232 8-18-58 et
CERTIFICATE OF DEATH

09230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>4 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Daughter's home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u> d. STREET ADDRESS <u>1610 University Blvd. East</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Stanford</u> Last <u>Natling</u> 4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1958</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3 Sept 1895</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Dothan, Alabama</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		13. FATHER'S NAME <u>Will Stanford</u> 14. MOTHER'S MAIDEN NAME <u>Nannie Story</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Daughter</u> Address <u>610 University Blvd East Silver Spring, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Arteriosclerotic Heart Disease</u> DUE TO <u>+ Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) <u>15 years</u> DUE TO (c) <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - Gastrointestinal Bleeding</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4 August 1958</u> , to <u>5 August 1958</u> , that I last saw the deceased alive on <u>4 August 1958</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D. <u>8801 Collesville Road</u> <u>8/5/58</u> PHYSICIAN'S NAME (Type) <u>Russell B. Arnold</u> <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Aug-9-1958</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Road</u> 22d. LOCATION (City, town, or county) (State) <u>Rehoboth Beach</u> <u>Delaware</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll St. - S.E.</u> 24a. REC'D BY REGISTRAR <u>AUG 7 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

9249

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 5304 Flanders Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5304 Flanders Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Victoria Middle GOFFREDO Last GOFFREDO				4. DATE OF DEATH Month August Day 3 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 15, 1895	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 3 Days 18		IF UNDER 24 HRS. Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Francisco Iafolla				14. MOTHER'S MAIDEN NAME Angelina Grasso			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 232-58-2872		17. INFORMANT Angelo G. Goffredo-Same Item #2-husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure and Pulmonary edema DUE TO Carcinoma of tongue with cervical lymph node metastases Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 141.9 (c) 3 Months				INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 3, 1958 , to August 3, 1958 , that I last saw the deceased alive on August 3, 1958 , and that death occurred at 10:25 P.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Andrew J. Brennan M.D.							
PHYSICIAN'S NAME (Type) Andrew J. Brennan, M.D.				4630 Montgomery Ave. Bethesda, Md 8/4/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/48		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR DATE AUG 6 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Martin Luther King, Jr.		April 4, 1968	
Place of Birth		Date of Birth	
Atlanta, Georgia		January 15, 1929	
Residence at Time of Death		Occupation	
Room 906, Lorraine Motel, Memphis, Tennessee		Minister of the Gospel	
Cause of Death		Manner of Death	
Heart Attack		Suicide	
Physician's Name		Hospital Name	
Dr. J. V. Smith		Graceland Hospital, Memphis, Tennessee	
Signature of Physician		Signature of Coroner	
[Signature]		[Signature]	
Date of Certificate		Place of Issuance	
April 5, 1968		Memphis, Tennessee	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9250

CERTIFICATE OF DEATH

09232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b X Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6302 Valley Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Julia Darden Goolsby			4. DATE OF DEATH Month August Day 26 Year 19 58				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/1878		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Sanford M. Warren			14. MOTHER'S MAIDEN NAME Mary Louisa Edwards				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO.		17. INFORMANT S. M. Warren Address 6302 Valley Road, Bethesda, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pelvic Carcinoma PROBABLY OVARIAN 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) With extension to intestine - DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19 55 , to Aug 26 19 58 , that I last saw the deceased alive on Aug 20 19 58 , and that death occurred at 10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard E. DeBotts				ADDRESS (Street, city or town, state) 1150 Conn. Ave. N.W. DC.		DATE SIGNED 8/26/58	
PHYSICIAN'S NAME (Type) RICHARD E. DEBOTT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Prince Georges County, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE AUG 27 58	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is hereby filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
AGE		SEX	
35		Male	
RACE		RELIGION	
White		Methodist	
BIRTH DATE		BIRTH PLACE	
JAN 19 1933		MOBILE, ALABAMA	
MARRIAGE DATE		MARRIAGE PLACE	
None		None	
OCCUPATION		EDUCATION	
Attorney		High School	
CAUSE OF DEATH		MANNER OF DEATH	
Myocardial Infarction		Natural	
IMMEDIATE CAUSE		PREVAILING DISEASE	
Coronary Atherosclerosis		Coronary Atherosclerosis	
INTERVIEWED BY		DATE	
J. Edgar Hoover		APRIL 10, 1968	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
James Earl Ray		J. Edgar Hoover	
DATE		DATE	
APRIL 10, 1968		APRIL 10, 1968	

RECEIVED
APR 10 1968
FBI - BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9251

CERTIFICATE OF DEATH

Reg. Dist. No. 215

09233

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>38 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Lindsay</u> 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>Post Office Box 32</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Horace</u> Last <u>GRAHAM</u>				4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 June 1886</u>		9. AGE (In years last birthday) yrs. <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner, U.S. Marine Corps, Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. GRAHAM</u>				14. MOTHER'S MAIDEN NAME <u>Mary HILL</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Son, Walter Harry Graham (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma right lung with</u> DUE TO (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 July</u> , 19 <u>58</u> , to <u>13 August</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12 August</u> , 19 <u>58</u> , and that death occurred at <u>5:20 A.</u> M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>J. E. McClenathan</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>8-13-58</u>					
PHYSICIAN'S NAME (Type) <u>J. E. MC CLENATHAN, CDR, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>8-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R. A. Humphrey, 1537 Wisconsin Ave., Bethesda, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>AUG 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1975</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1975</u></p>		<p>12. Place of registration: <u>NEW YORK</u></p>	
<p>13. Name of informant: <u>[Name]</u></p>		<p>14. Address of informant: <u>[Address]</u></p>	
<p>15. Date of completion: <u>1975</u></p>		<p>16. Place of completion: <u>NEW YORK</u></p>	

44-6000

RECEIVED
BALTIMORE
MAY 1975

9252

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Home of Rest		d. STREET ADDRESS 1817 Lamont St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sue Crossman Gray		4. DATE OF DEATH August 1, 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. D. Crossman		14. MOTHER'S MAIDEN NAME Ida Cain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George V. Menke, Address Barnesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized arteriosclerosis, severe.			INTERVAL BETWEEN ONSET AND DEATH 1 mo. 1 yr. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture, Left hip, 2/3/58			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 29, 1958 , to Aug 1, 1958 , that I last saw the deceased alive on Aug 1, 1958 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. N. Hindman M.D.		ADDRESS (Street, city or town, state) 3935 Baltimore St. Kensington, Md. DATE SIGNED 8/1/58	
PHYSICIAN'S NAME (Type) Thomas A. N. Hindman			
22a. BURIAL, CREMATION, REMOVAL SPECIAL 8/4/58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Pr. Geo. Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR Aug 4 '58	24b. REGISTRAR'S SIGNATURE Alfred

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9253

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5003 Euclid Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle James Last HAGEN				4. DATE OF DEATH Month August Day 11 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 April 1908		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner, U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harry G. HAGEN				14. MOTHER'S MAIDEN NAME Josephine MOBLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW-II		17. INFORMANT Address (Wife) Mrs. Zena Hagen (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 150x IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) TRACHEO-ESOPHAGEAL FISTULA DUE TO (c) CARCINOMA OF ESOPHAGUS						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 2 MONTHS 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 August , 19 58 , to 11 August , 19 58 , that I last saw the deceased alive on 11 August , 19 58 , and that death occurred at 8:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George W. Taylor Sr. M.D. U.S. Naval Hospital, Bethesda, Md. 8-12-58							
ACTUAL SIGNATURE George W. Taylor Sr. M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) GEORGE W. TAYLOR, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR AUG 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

9254

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gainesboro 83X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Catherine Last Haines				4. DATE OF DEATH Month August Day 27 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1918	
9. AGE (In years last birthday) yrs. 40		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Robert Nixon		14. MOTHER'S MAIDEN NAME Ethel Mullin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - antero septal 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease - severe DUE TO Fibroadipose nodule - R.U.L. (c) Central + thickening, left Tibia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 1 - 2 weeks		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 17, 1958 , to August 27, 1958 , that I last saw the deceased alive on August 27, 1958 , and that death occurred at 7:05 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon G. Smith		M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 8-27-58	
PHYSICIAN'S NAME (Type) Leon G. Smith, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 8-29-58		22c. NAME OF CEMETERY OR CREMATORY Capon Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Hampshire County, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert W. Humphrey		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kears	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. Smith		Male		45		Jan 15, 1900		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Physician's Title	
Jan 20, 1945		10:30 AM		Home		J. H. Jones		M.D.	
Signature of Informant		Relationship to Deceased		Signature of Physician		Signature of Registrar		Signature of Coroner	
Mary A. Smith		Wife		J. H. Jones		J. H. Jones		J. H. Jones	
Address		City		State		County		Zip	
123 Main St.		Baltimore		Md.		Baltimore		21201	
Telephone		Occupation		Education		Religion		Race	
123-4567		Teacher		High School		Catholic		White	
Marital Status		Previous Marriages		Number of Children		Date of Marriage		Date of Divorce	
Married		None		2		1925		None	
Date of Marriage		Date of Divorce		Date of Death		Date of Burial		Date of Interment	
1925		None		1945		1945		1945	
Date of Burial		Date of Interment		Date of Death		Date of Burial		Date of Interment	
1945		1945		1945		1945		1945	

1. This certificate is to be filled out by the physician who attended the deceased or by the coroner if the death was sudden or unexpected.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or coroner.

3. The manner of death should be stated as natural, accidental, suicidal, or homicidal.

4. The place of death should be stated as home, hospital, or other.

5. The date of death should be stated in full, including the day, month, and year.

6. The time of death should be stated in full, including the hour, minute, and second.

7. The signature of the physician or coroner should be written in ink.

8. The signature of the registrar should be written in ink.

9. The signature of the informant should be written in ink.

10. The address, city, state, county, and zip should be written in ink.

11. The telephone, occupation, education, religion, race, marital status, previous marriages, number of children, date of marriage, date of divorce, date of burial, date of interment, date of death, date of burial, and date of interment should be written in ink.

1. **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
9255
CERTIFICATE OF DEATH

09237

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 3 mos. 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle (nmn) Last HALLA				4. DATE OF DEATH Month August Day 29 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 Sept. 1897	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Herman HALLA				14. MOTHER'S MAIDEN NAME Minnie MUCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I & II				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Blanche R. HALLA (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4 May , 19 58 , to 29 August , 19 58 , that I last saw the deceased alive on 28 August , 19 58 , and that death occurred at 4:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gerald D. Faulkner M.D.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-29-58			
PHYSICIAN'S NAME (Type) Gerald D. Faulkner, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md. 8-29-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-2-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines, 2901 14th St., N.W. Washington, D.C.				24a. REC'D BY REGISTRAR SEP 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9256

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X. BETHESDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>16923 CLARENDON RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY CATHERINE HAMILTON</u>				4. DATE OF DEATH Month Day Year <u>AUG 7 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 2 1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO - MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>HOFMAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY C. H.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-50-5861</u>			
17. INFORMANT <u>Son</u> Address <u>Edward O Hamilton-5419 Uppingham St. Ch.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>several years</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>491X BRONCHO PNEUMONIA</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 8, 1958</u> to <u>Aug 7, 1958</u> , that I last saw the deceased alive on <u>Aug 7, 1958</u> , and that death occurred at <u>1230 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michel M. Healy</u>				ADDRESS (Street, city or town, state) <u>Washington Clinic Wash DC</u> DATE SIGNED <u>8/7/58</u>			
PHYSICIAN'S NAME (Type) <u>Michel M. Healy</u>				Washington Clinic, Wash. D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— — —

— — —

9257

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 22 hours		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Hugh Middle Groseclose Last HARMON			4. DATE OF DEATH Month August Day 9 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-12		9. AGE (In years last birthday) 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Landscaping		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Samuel T. HARMON			14. MOTHER'S MAIDEN NAME Ella MAE GROSECLOSE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-03-1511		17. INFORMANT Mrs. Alice R. HARMAN (Wife), same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 330x IMMEDIATE CAUSE (a) Hemorrhage, subarachnoid DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 6 22 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DAID			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from August 8 , 19 58 , to August 9 , 19 58 , that I last saw the deceased alive on August 9 , 19 58 , and that death occurred at 6:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 8-9-58					
ACTUAL SIGNATURE Thomas A. Smith M.D. U. S. Naval Hospital, NMMC 8-9-58					
PHYSICIAN'S NAME (Type) Thomas A. SMITH LT MC USN Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-12-58		22c. NAME OF CEMETERY OR CREMATORY Forest Oak	
22d. LOCATION (City, town, or county) Gaithersburg, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY			24a. REC'D BY REGISTRAR AUG 12 1958		
24b. REGISTRAR'S SIGNATURE Arthur L. Francis					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G233 9-2-58 et.

CERTIFICATE OF DEATH

09240

Reg. Dist. No.

9199

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colman Manor</u> 16 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>405 Baltimore Ave.</u>		d. STREET ADDRESS <u>3406-39th street</u>	
3. NAME OF DECEASED (Type or print) <u>Rosa E. Harris</u>		4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/83</u>
9. AGE (In years last birthday) <u>74 7/8</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Clayville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clifton A. Harris Hyattsville, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of bladder</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>4-6 mos</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-11</u> , 19 <u>58</u> , to <u>8-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-18</u> , 19 <u>58</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. G. Hall</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 615 W. Montgomery Ave. - Rockville, Md. 8-19-58</u>	
PHYSICIAN'S NAME (Type) <u>W. G. Hall</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8/22/58</u>	<u>Fort Lincoln</u>	<u>Colman Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 22 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Franz</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: JOHN J. BROWN

2. Sex: Male

3. Age: 65

4. Date of Birth: 1900

5. Place of Birth: NEW YORK

6. Date of Death: 1965

7. Time of Death: 10:00 AM

8. Cause of Death: Heart Disease

9. Place of Death: Home

10. Signature of Physician: [Signature]

11. Signature of Registrar: [Signature]

12. Date of Registration: 1965



THE OFFICIAL RECORD OF THE DEATH OF THE DECEASED IS THE PROPERTY OF THE STATE OF MARYLAND AND IS LOANED TO YOU BY THE STATE DEPARTMENT OF HEALTH. IT IS TO BE KEPT IN YOUR OFFICE AND IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, 3 and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. If the body is to be retained for your files, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9258 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09241

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>Bexar</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 wk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9815 Singleton Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nora Ellen Harwood</u>		4. DATE OF DEATH <u>Aug 7 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		9. AGE (In years last birthday) <u>79</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ky.</u>	
13. FATHER'S NAME <u>T.H. Colgrove</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Tabitha ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Clare Harwood</u> Address <u>Stm 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Albermarle, North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon</u>		ADDRESS <u>3831-Ga.Ave.N.W.</u>	
24a. REC'D BY REGISTRAR <u>AUG 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.
M

1. Name of Deceased: JOHN J. BROWN

2. Date of Death: 10-15-1968

3. Place of Death: Home

4. Age: 65

5. Sex: Male

6. Race: White

7. Marital Status: Married

8. Occupation: Retired

9. Usual Residence: 1234 Main St., Baltimore, Md.

10. Cause of Death: Myocardial Infarction

11. Manner of Death: Natural

12. Signature of Medical Examiner: [Signature]

13. Date of Certification: 10-16-1968

14. Address of Medical Examiner: 5678 Elm St., Baltimore, Md.

15. Telephone Number: 555-1234

16. Name of Coroner: [Signature]

17. Date of Certification: 10-16-1968

18. Address of Coroner: 9010 Pine St., Baltimore, Md.

19. Telephone Number: 555-5678

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9259

Item 1 Film 0233 8/28/58 771

CERTIFICATE OF DEATH

09242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville Fairland	
c. LENGTH OF STAY IN 1b 357 days		d. STREET ADDRESS Musgrove & Marlow Rds. 6509 20th Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harold Middle Douglas Last Haynes		4. DATE OF DEATH Month August Day 22 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1909
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis F. Haynes		14. MOTHER'S MAIDEN NAME Margaret Stanger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-07-7751	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 2 ventricular fibrillation 3 minutes 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of cerebral thrombosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1957 , to August 22, 1958 , that I last saw the deceased alive on August 22, 1958 , and that death occurred at 7:35 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Alan F. Hofmann M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/24/58	
PHYSICIAN'S NAME (Type) Alan F. Hofmann, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 27, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George's County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR AUG 26 '58 DATE AUG 26 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

9186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8627 Flower Avenue		d. STREET ADDRESS 8627 Flower Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHESTER Middle E Last HEISEY		4. DATE OF DEATH Month August Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 3 Days 25 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Haberdashery		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Edward Heisey		14. MOTHER'S MAIDEN NAME Ella Erbb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 265-12-7299	
17. INFORMANT Ruth P. Heisey-Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 19 Aug 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/22/58	22c. NAME OF CEMETERY OR CREMATORY Kraybill Cem.	22d. LOCATION (City, town, or county) (State) Mt. Joy, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR AUG 21 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9703 Cedar Lane		d. STREET ADDRESS 9703 Cedar Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle LOUIS Last HEMLINGE		4. DATE OF DEATH Month August Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Professor	
11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Phillippe Helmlinge		14. MOTHER'S MAIDEN NAME Barbara Nippert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW1		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. F. Smith-daughter-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. atrio-ventricular dissociation DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. Aug 16 19 58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 13 , 19 58 , to Aug 18 , 19 58 , that I last saw the deceased alive on Aug 17 , 19 58 , and that death occurred at 7:30 M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Robert E. Moran Jr. M.D.		1532-16th St. N. W. Wash. D. C 8/17/58	
PHYSICIAN'S NAME (Type) Robert E. Moran, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 8/22/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE AUG 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2280

NAME OF DECEASED ROBERT A. CIGAN, JR.		SEX MALE		AGE 34	
DATE OF BIRTH 10/15/28		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE	
DATE OF DEATH 11/15/62		PLACE OF DEATH BALTIMORE, MARYLAND		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH MYOCARDIAL INFARCTION		MANNER OF DEATH NATURAL		PLACE OF INTERMENT GREENWICH CEMETERY	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]		DATE OF REGISTRATION 11/16/62	
ADDRESS OF DECEASED 1234 E. BALTIMORE AVE.		ADDRESS OF NEXT OF KIN 1234 E. BALTIMORE AVE.		ADDRESS OF REGISTRAR 1234 E. BALTIMORE AVE.	
OCCUPATION OF DECEASED ENGINEER		OCCUPATION OF NEXT OF KIN ENGINEER		OCCUPATION OF REGISTRAR ENGINEER	
MARITAL STATUS MARRIED		DATE OF MARRIAGE 05/15/55		NAME OF SPOUSE MARY ANN CIGAN	
PREVIOUS MARRIAGES NONE		DATE OF PREVIOUS MARRIAGE NONE		NAME OF PREVIOUS SPOUSE NONE	
EDUCATION HIGH SCHOOL		DATE OF EDUCATION 1945		NAME OF EDUCATIONAL INSTITUTION BALTIMORE CITY SCHOOLS	
RELIGION ROMAN CATHOLIC		DATE OF RELIGION 1945		NAME OF RELIGIOUS INSTITUTION ST. ANNE'S CHURCH	
SERVICE RECORD NONE		DATE OF SERVICE RECORD NONE		NAME OF SERVICE INSTITUTION NONE	
OTHER INFORMATION NONE		DATE OF OTHER INFORMATION NONE		NAME OF OTHER INSTITUTION NONE	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9261
CERTIFICATE OF DEATH

09245

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 60 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS R. D. #2			
3. NAME OF DECEASED (Type or print) First Douglas Middle Lee Last Hepler				4. DATE OF DEATH Month August Day 11 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 October 1949	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Charles Hepler				14. MOTHER'S MAIDEN NAME Anna Ruth Nolt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia 204.3 DUE TO (b) Acute Hemorrhagic Meningoencephalitis DUE TO (c) Generalized petechial hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 12 , 19 58 , to August 11 , 19 58 , that I last saw the deceased alive on August 11 , 19 58 , and that death occurred at 8:35 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Leonard Garren				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/12/58			
PHYSICIAN'S NAME (Type) LEONARD GARREN, M.D.				Bathesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/58		22c. NAME OF CEMETERY OR CREMATORY Silver Spring		22d. LOCATION (City, town, or county) (State) Lancaster Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS 7557 Wisc Ave Beth Md				24a. REC'D BY REGISTRAR AUG 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

9262

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Denise Middle Diane Last Hill		4. DATE OF DEATH Month August Day 6 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1955
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Child	11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert L. Hill	
14. MOTHER'S MAIDEN NAME Dorothy Jones		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 7543 DUE TO postoperative correction of total anomalous pulmonary venous drainage, atrial septal defect and patent ductus arteriosus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 13, 1958 to August 6, 1958 , that I last saw the deceased alive on August 6, 1958 , and that death occurred at 9:00A , from the causes and on the date stated above.			
ACTUAL SIGNATURE N. Perryman Collins M.D.		ADDRESS (Street, city or town, state) The Clinical Center 8/6/58 DATE SIGNED	
PHYSICIAN'S NAME (Type) N. Perryman Collins, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-8-58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Orange	22d. LOCATION (City, town, or county) (State) NC
23. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home		24a. REC'D BY REGISTRAR DATE AUG 8 '58	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100:4

9263

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,				c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5707 Glenwood Rd., Bethesda, Md.				e. STREET ADDRESS 5707 Glenwood Rd.,			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Minnie Middle Adelia Last Hillman				4. DATE OF DEATH Month August Day 23 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1872	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 8 Days 5		IF UNDER 24 HRS. Hours 5 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Stowe, Vermont	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Douglas				14. MOTHER'S MAIDEN NAME Hattie Monroe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Helen Hillman Stahl Address 5707 Glenwood Rd., Beth., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, abdominal 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, stomach DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from June 14 , 19 57 , to August 23 , 19 58 , that I last saw the deceased alive on August 19 , 19 58 , and that death occurred at 4:50 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle				ADDRESS (Street, city or town, state) 5009 Del Ray Avenue, Bethesda, Md. DATE SIGNED 8/23/58			
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/23/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

CERTIFICATE OF DEATH

Form No. 10

Name of Deceased		Date of Death	
John A. Smith		1945	
Age		Sex	
35		Male	
Place of Birth		Date of Birth	
Baltimore, Md.		1910	
Usual Residence		Date of Residence	
Baltimore, Md.		1945	
Cause of Death		Place of Death	
Heart Disease		Home	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Artery Disease	
Manner of Death		Signature of Physician	
Natural		[Signature]	
Certified by		Date of Certification	
[Signature]		1945	
Registrar		County	
[Signature]		Baltimore	
Date of Registration		Place of Registration	
1945		Baltimore, Md.	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A REGISTRAR OF DEATHS.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Rosalie Patricia Hines		4. DATE OF DEATH Month Day Year August 16 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1922
9. AGE (In years last birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John L. Hines	
14. MOTHER'S MAIDEN NAME Catherine Rhodes		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mother Address Catherine Dwyer As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fastidious Fastum 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobar Pneumonia DUE TO (c) Pneumococcus Infection		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 days undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute diarrhea		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1954 , to 8/16/58 , that I last saw the deceased alive on 8/16/58 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 8/16/58			
ACTUAL SIGNATURE Stephen N. Jones M.D.		PHYSICIAN'S NAME (Type) Stephen N. Jones Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/19/48	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE AUG 19 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[The page contains faint, illegible text, likely bleed-through from the reverse side.]

9265

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>4006 Rosemary St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HAZEL</u> Middle <u>J.</u> Last <u>HOLLINGS HEAD</u>				4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22, 1886</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Henry Thomas Buckle Moye</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Dunaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Evelyn H. Curran, 4006 Rosemary St., C.C.Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Aug. 8 - Sept. 22</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Feb. 19, 1954</u> to <u>Aug. 22, 1958</u> , that I last saw the deceased alive on <u>Aug. 14, 1958</u> , and that death occurred at <u>1038</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Geo. A. Gray, Jr.</u>				M.D. <u>104 Chevy Chase Rd. Chevy Chase, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Geo. A. Gray, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 26, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				24a. REC'D BY REGISTRAR <u>AUG 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED'S NAME JOHN J. ROBERTSON		2. SEX MALE	
3. DATE OF BIRTH 1910		4. PLACE OF BIRTH NEW YORK	
5. DATE OF DEATH 1960		6. PLACE OF DEATH NEW YORK	
7. DECEASED'S RESIDENCE NEW YORK		8. DECEASED'S OCCUPATION NEW YORK	
9. DECEASED'S MARITAL STATUS MARRIED		10. DECEASED'S RELIGION CATHOLIC	
11. DECEASED'S RACE WHITE		12. DECEASED'S COLOR WHITE	
13. DECEASED'S HEIGHT 5' 10"		14. DECEASED'S WEIGHT 170	
15. DECEASED'S BUILD WELL		16. DECEASED'S COMPLEXION Fair	
17. DECEASED'S HAIR Brown		18. DECEASED'S EYES Blue	
19. DECEASED'S MOUTH Good		20. DECEASED'S TEETH Good	
21. DECEASED'S NOSE Good		22. DECEASED'S EARS Good	
23. DECEASED'S SKIN Good		24. DECEASED'S FINGER NAILS Good	
25. DECEASED'S TOE NAILS Good		26. DECEASED'S FEET Good	
27. DECEASED'S HANDS Good		28. DECEASED'S WRISTS Good	
29. DECEASED'S ELBOWS Good		30. DECEASED'S SHOULDERS Good	
31. DECEASED'S NECK Good		32. DECEASED'S THROAT Good	
33. DECEASED'S CHEST Good		34. DECEASED'S BACK Good	
35. DECEASED'S ABDOMEN Good		36. DECEASED'S PELVIS Good	
37. DECEASED'S GENITALS Good		38. DECEASED'S ANUS Good	
39. DECEASED'S UTERUS Good		40. DECEASED'S VAGINA Good	
41. DECEASED'S BLOOD Good		42. DECEASED'S URINE Good	
43. DECEASED'S FECES Good		44. DECEASED'S SWEAT Good	
45. DECEASED'S SALIVA Good		46. DECEASED'S TEAR FLUID Good	
47. DECEASED'S SPERM Good		48. DECEASED'S OVUM Good	
49. DECEASED'S EMBRYO Good		50. DECEASED'S FETUS Good	
51. DECEASED'S PLACENTA Good		52. DECEASED'S CORD Good	
53. DECEASED'S AMNION Good		54. DECEASED'S PERITONEUM Good	
55. DECEASED'S PERICARDIUM Good		56. DECEASED'S PLEURA Good	
57. DECEASED'S LUNG Good		58. DECEASED'S LIVER Good	
59. DECEASED'S GALLBLADDER Good		60. DECEASED'S PANCREAS Good	
61. DECEASED'S SPLEEN Good		62. DECEASED'S STOMACH Good	
63. DECEASED'S SMALL INTESTINE Good		64. DECEASED'S LARGE INTESTINE Good	
65. DECEASED'S RECTUM Good		66. DECEASED'S ANUS Good	
67. DECEASED'S UTERUS Good		68. DECEASED'S VAGINA Good	
69. DECEASED'S BLOOD Good		70. DECEASED'S URINE Good	
71. DECEASED'S FECES Good		72. DECEASED'S SWEAT Good	
73. DECEASED'S SALIVA Good		74. DECEASED'S TEAR FLUID Good	
75. DECEASED'S SPERM Good		76. DECEASED'S OVUM Good	
77. DECEASED'S EMBRYO Good		78. DECEASED'S FETUS Good	
79. DECEASED'S PLACENTA Good		80. DECEASED'S CORD Good	
81. DECEASED'S AMNION Good		82. DECEASED'S PERITONEUM Good	
83. DECEASED'S PERICARDIUM Good		84. DECEASED'S PLEURA Good	
85. DECEASED'S LUNG Good		86. DECEASED'S LIVER Good	
87. DECEASED'S GALLBLADDER Good		88. DECEASED'S PANCREAS Good	
89. DECEASED'S SPLEEN Good		90. DECEASED'S STOMACH Good	
91. DECEASED'S SMALL INTESTINE Good		92. DECEASED'S LARGE INTESTINE Good	
93. DECEASED'S RECTUM Good		94. DECEASED'S ANUS Good	
95. DECEASED'S UTERUS Good		96. DECEASED'S VAGINA Good	
97. DECEASED'S BLOOD Good		98. DECEASED'S URINE Good	
99. DECEASED'S FECES Good		100. DECEASED'S SWEAT Good	
101. DECEASED'S SALIVA Good		102. DECEASED'S TEAR FLUID Good	
103. DECEASED'S SPERM Good		104. DECEASED'S OVUM Good	
105. DECEASED'S EMBRYO Good		106. DECEASED'S FETUS Good	
107. DECEASED'S PLACENTA Good		108. DECEASED'S CORD Good	
109. DECEASED'S AMNION Good		110. DECEASED'S PERITONEUM Good	
111. DECEASED'S PERICARDIUM Good		112. DECEASED'S PLEURA Good	
113. DECEASED'S LUNG Good		114. DECEASED'S LIVER Good	
115. DECEASED'S GALLBLADDER Good		116. DECEASED'S PANCREAS Good	
117. DECEASED'S SPLEEN Good		118. DECEASED'S STOMACH Good	
119. DECEASED'S SMALL INTESTINE Good		120. DECEASED'S LARGE INTESTINE Good	
121. DECEASED'S RECTUM Good		122. DECEASED'S ANUS Good	
123. DECEASED'S UTERUS Good		124. DECEASED'S VAGINA Good	
125. DECEASED'S BLOOD Good		126. DECEASED'S URINE Good	
127. DECEASED'S FECES Good		128. DECEASED'S SWEAT Good	
129. DECEASED'S SALIVA Good		130. DECEASED'S TEAR FLUID Good	
131. DECEASED'S SPERM Good		132. DECEASED'S OVUM Good	
133. DECEASED'S EMBRYO Good		134. DECEASED'S FETUS Good	
135. DECEASED'S PLACENTA Good		136. DECEASED'S CORD Good	
137. DECEASED'S AMNION Good		138. DECEASED'S PERITONEUM Good	
139. DECEASED'S PERICARDIUM Good		140. DECEASED'S PLEURA Good	
141. DECEASED'S LUNG Good		142. DECEASED'S LIVER Good	
143. DECEASED'S GALLBLADDER Good		144. DECEASED'S PANCREAS Good	
145. DECEASED'S SPLEEN Good		146. DECEASED'S STOMACH Good	
147. DECEASED'S SMALL INTESTINE Good		148. DECEASED'S LARGE INTESTINE Good	
149. DECEASED'S RECTUM Good		150. DECEASED'S ANUS Good	
151. DECEASED'S UTERUS Good		152. DECEASED'S VAGINA Good	
153. DECEASED'S BLOOD Good		154. DECEASED'S URINE Good	
155. DECEASED'S FECES Good		156. DECEASED'S SWEAT Good	
157. DECEASED'S SALIVA Good		158. DECEASED'S TEAR FLUID Good	
159. DECEASED'S SPERM Good		160. DECEASED'S OVUM Good	
161. DECEASED'S EMBRYO Good		162. DECEASED'S FETUS Good	
163. DECEASED'S PLACENTA Good		164. DECEASED'S CORD Good	
165. DECEASED'S AMNION Good		166. DECEASED'S PERITONEUM Good	
167. DECEASED'S PERICARDIUM Good		168. DECEASED'S PLEURA Good	
169. DECEASED'S LUNG Good		170. DECEASED'S LIVER Good	
171. DECEASED'S GALLBLADDER Good		172. DECEASED'S PANCREAS Good	
173. DECEASED'S SPLEEN Good		174. DECEASED'S STOMACH Good	
175. DECEASED'S SMALL INTESTINE Good		176. DECEASED'S LARGE INTESTINE Good	
177. DECEASED'S RECTUM Good		178. DECEASED'S ANUS Good	
179. DECEASED'S UTERUS Good		180. DECEASED'S VAGINA Good	
181. DECEASED'S BLOOD Good		182. DECEASED'S URINE Good	
183. DECEASED'S FECES Good		184. DECEASED'S SWEAT Good	
185. DECEASED'S SALIVA Good		186. DECEASED'S TEAR FLUID Good	
187. DECEASED'S SPERM Good		188. DECEASED'S OVUM Good	
189. DECEASED'S EMBRYO Good		190. DECEASED'S FETUS Good	
191. DECEASED'S PLACENTA Good		192. DECEASED'S CORD Good	
193. DECEASED'S AMNION Good		194. DECEASED'S PERITONEUM Good	
195. DECEASED'S PERICARDIUM Good		196. DECEASED'S PLEURA Good	
197. DECEASED'S LUNG Good		198. DECEASED'S LIVER Good	
199. DECEASED'S GALLBLADDER Good		200. DECEASED'S PANCREAS Good	
201. DECEASED'S SPLEEN Good		202. DECEASED'S STOMACH Good	
203. DECEASED'S SMALL INTESTINE Good		204. DECEASED'S LARGE INTESTINE Good	
205. DECEASED'S RECTUM Good		206. DECEASED'S ANUS Good	
207. DECEASED'S UTERUS Good		208. DECEASED'S VAGINA Good	
209. DECEASED'S BLOOD Good		210. DECEASED'S URINE Good	
211. DECEASED'S FECES Good		212. DECEASED'S SWEAT Good	
213. DECEASED'S SALIVA Good		214. DECEASED'S TEAR FLUID Good	
215. DECEASED'S SPERM Good		216. DECEASED'S OVUM Good	
217. DECEASED'S EMBRYO Good		218. DECEASED'S FETUS Good	
219. DECEASED'S PLACENTA Good		220. DECEASED'S CORD Good	
221. DECEASED'S AMNION Good		222. DECEASED'S PERITONEUM Good	
223. DECEASED'S PERICARDIUM Good		224. DECEASED'S PLEURA Good	
225. DECEASED'S LUNG Good		226. DECEASED'S LIVER Good	
227. DECEASED'S GALLBLADDER Good		228. DECEASED'S PANCREAS Good	
229. DECEASED'S SPLEEN Good		230. DECEASED'S STOMACH Good	
231. DECEASED'S SMALL INTESTINE Good		232. DECEASED'S LARGE INTESTINE Good	
233. DECEASED'S RECTUM Good		234. DECEASED'S ANUS Good	
235. DECEASED'S UTERUS Good		236. DECEASED'S VAGINA Good	
237. DECEASED'S BLOOD Good		238. DECEASED'S URINE Good	
239. DECEASED'S FECES Good		240. DECEASED'S SWEAT Good	
241. DECEASED'S SALIVA Good		242. DECEASED'S TEAR FLUID Good	
243. DECEASED'S SPERM Good		244. DECEASED'S OVUM Good	
245. DECEASED'S EMBRYO Good		246. DECEASED'S FETUS Good	
247. DECEASED'S PLACENTA Good		248. DECEASED'S CORD Good	
249. DECEASED'S AMNION Good		250. DECEASED'S PERITONEUM Good	
251. DECEASED'S PERICARDIUM Good		252. DECEASED'S PLEURA Good	
253. DECEASED'S LUNG Good		254. DECEASED'S LIVER Good	
255. DECEASED'S GALLBLADDER Good		256. DECEASED'S PANCREAS Good	
257. DECEASED'S SPLEEN Good		258. DECEASED'S STOMACH Good	
259. DECEASED'S SMALL INTESTINE Good		260. DECEASED'S LARGE INTESTINE Good	
261. DECEASED'S RECTUM Good		262. DECEASED'S ANUS Good	
263. DECEASED'S UTERUS Good		264. DECEASED'S VAGINA Good	
265. DECEASED'S BLOOD Good		266. DECEASED'S URINE Good	
267. DECEASED'S FECES Good		268. DECEASED'S SWEAT Good	
269. DECEASED'S SALIVA Good		270. DECEASED'S TEAR FLUID Good	
271. DECEASED'S SPERM Good		272. DECEASED'S OVUM Good	
273. DECEASED'S EMBRYO Good		274. DECEASED'S FETUS Good	
275. DECEASED'S PLACENTA Good		276. DECEASED'S CORD Good	
277. DECEASED'S AMNION Good		278. DECEASED'S PERITONEUM Good	
279. DECEASED'S PERICARDIUM Good		280. DECEASED'S PLEURA Good	
281. DECEASED'S LUNG Good		282. DECEASED'S LIVER Good	
283. DECEASED'S GALLBLADDER Good		284. DECEASED'S PANCREAS Good	
285. DECEASED'S SPLEEN Good		286. DECEASED'S STOMACH Good	
287. DECEASED'S SMALL INTESTINE Good		288. DECEASED'S LARGE INTESTINE Good	
289. DECEASED'S RECTUM Good		290. DECEASED'S ANUS Good	
291. DECEASED'S UTERUS Good		292. DECEASED'S VAGINA Good	
293. DECEASED'S BLOOD Good		294. DECEASED'S URINE Good	
295. DECEASED'S FECES Good		296. DECEASED'S SWEAT Good	
297. DECEASED'S SALIVA Good		298. DECEASED'S TEAR FLUID Good	
299. DECEASED'S SPERM Good		300. DECEASED'S OVUM Good	
301. DECEASED'S EMBRYO Good		302. DECEASED'S FETUS Good	
303. DECEASED'S PLACENTA Good		304. DECEASED'S CORD Good	
305. DECEASED'S AMNION Good		306. DECEASED'S PERITONEUM Good	
307. DECEASED'S PERICARDIUM Good		308. DECEASED'S PLEURA Good	
309. DECEASED'S LUNG Good		310. DECEASED'S LIVER Good	
311. DECEASED'S GALLBLADDER Good		312. DECEASED'S PANCREAS Good	
313. DECEASED'S SPLEEN Good		314. DECEASED'S STOMACH Good	
315. DECEASED'S SMALL INTESTINE Good		316. DECEASED'S LARGE INTESTINE Good	
317. DECEASED'S RECTUM Good		318. DECEASED'S ANUS Good	
319. DECEASED'S UTERUS Good		320. DECEASED'S VAGINA Good	
321. DECEASED'S BLOOD Good		322. DECEASED'S URINE Good	
323. DECEASED'S FECES Good		324. DECEASED'S SWEAT Good	
325. DECEASED'S SALIVA Good		326. DECEASED'S TEAR FLUID Good	
327. DECEASED'S SPERM Good		328. DECEASED'S OVUM Good	
329. DECEASED'S EMBRYO Good		330. DECEASED'S FETUS Good	
331. DECEASED'S PLACENTA Good		332. DECEASED'S CORD Good	
333. DECEASED'S AMNION Good		334. DECEASED'S PERITONEUM Good	
335. DECEASED'S PERICARDIUM Good		336. DECEASED'S PLEURA Good	
337. DECEASED'S LUNG Good		338. DECEASED'S LIVER Good	
339. DECEASED'S GALLBLADDER Good		340. DECEASED'S PANCREAS Good	
341. DECEASED'S SPLEEN Good		342. DECEASED'S STOMACH Good	
343. DECEASED'S SMALL INTESTINE Good		344. DECEASED'S LARGE INTESTINE Good	
345. DECEASED'S RECTUM Good		346. DECEASED'S ANUS Good	
347. DECEASED'S UTERUS Good		348. DECEASED'S VAGINA Good	
349. DECEASED'S BLOOD Good		350. DECEASED'S URINE Good	
351. DECEASED'S FECES Good		352. DECEASED'S SWEAT Good	
353. DECEASED'S SALIVA Good		354. DECEASED'S TEAR FLUID Good	
355. DECEASED'S SPERM Good		356. DECEASED'S OVUM Good	
357. DECEASED'S EMBRYO Good		358. DECEASED'S FETUS Good	
359. DECEASED'S PLACENTA Good		360. DECEASED'S CORD Good	
361. DECEASED'S AMNION Good		362. DECEASED'S PERITONEUM Good	
363. DECEASED'S PERICARDIUM Good		364. DECEASED'S PLEURA Good	
365. DECEASED'S LUNG Good		366. DECEASED'S LIVER Good	
367. DECEASED'S GALLBLADDER Good		368. DECEASED'S PANCREAS Good	
369. DECEASED'S SPLEEN Good		370. DECEASED'S STOMACH Good	
371. DECEASED'S SMALL INTESTINE Good		372. DECEASED'S LARGE INTESTINE Good	
373. DECEASED'S RECTUM Good		374. DECEASED'S ANUS Good	
375. DECEASED'S UTERUS Good		376. DECEASED'S VAGINA Good	
377. DECEASED'S BLOOD Good		378. DECEASED'S URINE Good	
379. DECEASED'S FECES Good		380. DECEASED'S SWEAT Good	
381. DECEASED'S SALIVA Good		382. DECEASED'S TEAR FLUID Good	
383. DECEASED'S SPERM Good		384. DECEASED'S OVUM Good	
385. DECEASED'S EMBRYO Good		386. DECEASED'S FETUS Good	
387. DECEASED'S PLACENTA Good		388. DECEASED'S CORD Good	
389. DECEASED'S AMNION Good		390. DECEASED'S PERITONEUM Good	
391. DECEASED'S PERICARDIUM Good		392. DECEASED'S PLEURA Good	
393. DECEASED'S LUNG Good		394. DECEASED'S LIVER Good	
39			

9266

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 80 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Albert Bernhardt Holtz				4. DATE OF DEATH Month Day Year August 17, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1917	
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Division Chief				10b. KIND OF BUSINESS OR INDUSTRY Internatnl. Coop. Adm.			
13. FATHER'S NAME Albert F. Holtz				14. MOTHER'S MAIDEN NAME Mary Farley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 309-18-8339		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Plural effusion + hypostatic pneumonia DUE TO (c) Carcinoma of Pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? hyper erythematosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 29 , 19 58 , to August 17 , 19 58 , that I last saw the deceased alive on August 17 , 19 58 , and that death occurred at 10:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 8-18-58 The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Bushnell Smith MD M.D.				PHYSICIAN'S NAME (Type) Bushnell Smith, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/20/1958		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gauder ADDRESS 1756 Penna., Ave., NW Washington 6, DC				24a. REC'D BY REGISTRAR DATE AUG 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FBI
JAN 10 1968

STATE OF CALIFORNIA - ALBANY - ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

ALBANY, NY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09251

9267

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56		d. STREET ADDRESS 2706 Navarre Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Mildred Horn		4. DATE OF DEATH Month Day Year August 17 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 25, 1915
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Secretarial	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Lazar		14. MOTHER'S MAIDEN NAME Lena Yudkovitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-34-0488	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 36 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic carcinoma of Breast - 3 years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 16, 1958 , to August 17, 1958 , that I last saw the deceased alive on August 17, 1958 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 8/18/58 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE James A. Rose, M.D.		M.D. James A. Rose, M.D.	
PHYSICIAN'S NAME (Type) James A. Rose, M. D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 18, 1958	
22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		22d. LOCATION (City, town, or county) (State) Falls Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		ADDRESS 3501 14th St., N.W.	
24a. REC'D BY REGISTRAR DATE AUG 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

CERTIFICATE OF DEATH

2561

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		10-15-1915	
Residence		Occupation		Cause of Death		Place of Death	
123 Main St, Baltimore, Md		Teacher		Heart Disease		Home	
Physician		Hospital		Date of Death		Time of Death	
Dr. J. Smith		St. Mary's Hospital		10-20-1960		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]	
Date of Filing		Filing Office		Filing Number		Filing Date	
10-25-1960		Baltimore City Health Dept		100-123456		10-25-1960	

9268

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 217 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jeanne Middle Alice Last Houghton				4. DATE OF DEATH Month August Day 15 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1939	
9. AGE (In years lost birthday) yrs. 19		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Washington		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Edwin H. Houghton				14. MOTHER'S MAIDEN NAME Loretta Dunn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Nervous System Depression DUE TO 195.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Adeno-Carcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 hrs 4 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 10, 1958 , to August 15, 1958 , that I last saw the deceased alive on August 15, 1958 , and that death occurred at 5:35 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-16-58 ACTUAL SIGNATURE Theodore L. Goodfriend, M.D. PHYSICIAN'S NAME (Type) Theodore L. Goodfriend, M. D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 17, 1958		22c. NAME OF CEMETERY OR CREMATORY Mountain View Mem. Cem.		22d. LOCATION (City, town, or county) (State) Tacoma, Washington	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley Sons				ADDRESS 1756 Panna Ave		24a. REC'D BY REGISTRAR AUG 19 58	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

USA

Name of deceased		Sex		Age	
John Doe		Male		45	
Date of death		Place of death		Cause of death	
August 15, 1950		New York City, New York		Heart disease	
Occupation		Residence		Manner of death	
Teacher		123 Main St, New York, NY		Natural	
Signature of physician		Signature of registrar		Signature of informant	
[Signature]		[Signature]		[Signature]	
Date of registration		Place of registration		County	
August 16, 1950		New York City		New York	
Registrar's name		Registrar's title		Registrar's address	
John Smith		Registrar		123 Main St, New York, NY	
Signature of registrar		Signature of informant		Signature of physician	
[Signature]		[Signature]		[Signature]	
Date of registration		Place of registration		County	
August 16, 1950		New York City		New York	
Registrar's name		Registrar's title		Registrar's address	
John Smith		Registrar		123 Main St, New York, NY	
Signature of registrar		Signature of informant		Signature of physician	
[Signature]		[Signature]		[Signature]	

RECEIVED
NEW YORK CITY
AUG 16 1950
DEPT. OF HEALTH
BUREAU OF VITAL STATISTICS
NEW YORK CITY

CERTIFICATE OF DEATH

Reg. Dist. No.

09253

9269

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION En Route to Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Cecil Lambert Howes				4. DATE OF DEATH Month Day Year August 18 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/07	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Howes		14. MOTHER'S MAIDEN NAME Grace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-09-8656		17. INFORMANT Hospital Records		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Chronic 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sinus Tachycardia DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 wks. 4 wks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/1/ 19 58 , to 8/18/ 19 58 , that I last saw the deceased alive on 8/17/ 19 58 , and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED 8/19/58 ACTUAL SIGNATURE [Signature] M.D. [Signature] PHYSICIAN'S NAME (Type) J. W. Bird, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Sunshine - Montgomery County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR DATE AUG 22 58		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Form No. 10

1923

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Place of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		45		Jan 1, 1878		New York City		Baltimore, Md.		Heart Disease		Jan 15, 1923		City of Baltimore		J. B. Smith, M.D.		W. H. Jones		J. B. Smith	
13. Name of informant		14. Address of informant		15. Telephone number		16. Signature of informant		17. Date of completion		18. Registrar's office		19. Registrar's name		20. Registrar's address		21. Registrar's telephone		22. Registrar's signature		23. Registrar's date		24. Registrar's office	
John Doe		123 Main St.		1234		J. B. Smith		Jan 15, 1923		City of Baltimore		W. H. Jones		123 Main St.		1234		J. B. Smith		Jan 15, 1923		City of Baltimore	

9270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Cherry Chase</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Cherry Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		d. STREET ADDRESS <i>3700 Stewart Dr. Way</i>	
3. NAME OF DECEASED (Type or print) First <i>Frank</i> Middle <i>Simmons</i> Last <i>Hubbard</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>17</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/20/93</i>
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months <i>5</i> Days <i>27</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Aeronautics</i>	11. BIRTHPLACE (State or foreign country) <i>Mass.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>George Hubbard</i>	
14. MOTHER'S MAIDEN NAME <i>Elviny Taylor</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>WW 1</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>068-09-1532</i>		17. INFORMANT <i>Mrs. Marion A. Hubbard-wife-same as 2d</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive cardiac vascular disease</i> DUE TO <i>10 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>None</i> p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/13</i> , 19 <i>57</i> , to <i>present</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8/17/58</i> , 19 <i>58</i> , and that death occurred at <i>6:59 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Umhau</i> M.D.		ADDRESS (Street, city or town, state) <i>8805 Conn. Ave.</i> DATE SIGNED <i>8/17/58</i>	
PHYSICIAN'S NAME (Type) <i>JOHN B. UMAU</i>		<i>Cherry Chase Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/20/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>AUG 19 58</i>	24b. REGISTRAR'S SIGNATURE <i>Carolina S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9271 Item 9 Film G233 9-8-58 et
CERTIFICATE OF DEATH

09255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Rockville</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital</u>		d. STREET ADDRESS <u>1806 Bryce Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Thomas Hughes</u>		4. DATE OF DEATH <u>8/28/58</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/2/77</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Ann McMoran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James T. Hughes, Jr. - Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/3/58</u> to <u>8/28/58</u> that I last saw the deceased alive on <u>8/28/58</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Bird</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird</u>		DATE SIGNED <u>8/29/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Transit</u>		22b. DATE THEREOF <u>8/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Emaculate Conception</u>		22d. LOCATION (City, town, or county) (State) <u>Montclair, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

2011

ALLA BRODIE

Age 84

Name of Deceased		ALLA BRODIE	
Date of Birth		1926-01-15	
Place of Birth		Russia	
Sex		Female	
Race		Caucasian	
Marital Status		Widowed	
Occupation		Homemaker	
Cause of Death		Natural Causes	
Date of Death		2011-01-15	
Place of Death		Home	
Physician's Signature		[Signature]	
Physician's Name		Dr. [Name]	
Physician's Address		[Address]	
Physician's Phone		[Phone]	
Physician's License		[License]	
Medical Examiner's Signature		[Signature]	
Medical Examiner's Name		Dr. [Name]	
Medical Examiner's Address		[Address]	
Medical Examiner's Phone		[Phone]	
Medical Examiner's License		[License]	
Registrar's Signature		[Signature]	
Registrar's Name		[Name]	
Registrar's Address		[Address]	
Registrar's Phone		[Phone]	
Registrar's License		[License]	

12-10-11

9272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Fairfax</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>9 hours</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Falls Church 83X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. STREET ADDRESS <i>Montau Drive</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Robert Allen Inscow</i>		4. DATE OF DEATH Month Day Year <i>August 23 1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/27/1901</i>
9. AGE (In years last birthday) <i>56 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy</i>	11. BIRTHPLACE (State or foreign country) <i>King George Co. Va.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Robert Austin Inscow</i>	
14. MOTHER'S MAIDEN NAME <i>Mary B. Staples</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Pearl Inscow (Wife)</i> Address <i>see # 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Vascular Disease</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i> <i>10 years</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <i>1920</i> to <i>date</i> <i>1958</i> that I last saw the deceased alive on <i>August 23, 1958</i> and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John G. Ball</i>		ADDRESS (Street, city or town, state) <i>7936 Old Georgetown Rd Bethesda 14 Md</i>	
PHYSICIAN'S NAME (Type) <i>John G. Ball</i>		DATE SIGNED <i>Aug 26 '58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/26/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 26 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09257

9200

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) Waverley Sanitarium		d. STREET ADDRESS 4523 Middleton Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Allidee Middle IRVING Last IRVING		4. DATE OF DEATH Month August Day 14 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 0 Days 17 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Internal Rev.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Irving		14. MOTHER'S MAIDEN NAME Lillian Frazer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 2 hours 15 years 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 30, 19 52 , to August 14, 19 58 , that I last saw the deceased alive on July 13, 19 58 , and that death occurred at 7:40 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Angle M.D.		ADDRESS (Street, city or town, state) 5009 Del Ray Avenue DATE SIGNED Aug 15, 1958	
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>50A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1730 Park Rd. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>James M. Jeffery</u>		4. DATE OF DEATH <u>8-5-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR <u>1</u> Months <u>7</u> Days <u>11</u> Hours <u>Min.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Gardening</u>	
13. BIRTHPLACE (State or foreign country) <u>England</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.G.B.</u>	
15. FATHER'S NAME <u>William Jeffery</u>		16. MOTHER'S M maiden name <u>Sarah Jane Morris</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>045-26-9630</u>	
19. INFORMANT <u>Son</u>		Address <u>418 N. Jefferson</u>	
20. <u>Harold E. Jeffery</u>		Knightstown, Ind.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapsed while mowing lawn</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-5-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>8-7-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glencove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Knightstown, Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 11 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>	

9274

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>12109 Cascade Rd</u>			
3. NAME OF DECEASED (Type or print) <u>DAVID</u> <u>William</u> <u>Johns</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 5 1958</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>4</u> Hours <u>3</u>		11. IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
13. FATHER'S NAME <u>William E Johns</u>				14. MOTHER'S MAIDEN NAME <u>Meredith ANN Barton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Father - William E Johns</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis, bilateral</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fetal anoxia</u> DUE TO (c) <u>Prematurity</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/5</u> , 19 <u>58</u> , to <u>8/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/5</u> , 19 <u>58</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles Haverstick</u> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Aug 5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hosp - Bethesda, Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>44 Mount Vernon</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>AUG 21 '58</u>				DATE <u>AUG 21 '58</u>		DATE <u>AUG 21 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074255 XVI



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09260

9275

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles C. Johnson</u>				4. DATE OF DEATH Month Day Year <u>August 13 19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/85</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward Church Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records Olney, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446x</u> DUE TO <u>trauma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephroses Interstitial</u> DUE TO <u>arterio sclerosis</u> (c) <u>alcoholism</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.2</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/4</u> , 19 <u>58</u> , to <u>8/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/12</u> , 19 <u>58</u> , and that death occurred at <u>1:00</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>8/14/58</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Sandy Spring, Md.</u> PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gates of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Aspen Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R. L. Snowden, Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

10380

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. EDUCATION <i>High School</i>		12. RELIGION <i>Methodist</i>	
13. MARITAL STATUS <i>Married</i>		14. DATE OF MARRIAGE <i>Jan 1 1945</i>		15. NAME OF SPOUSE <i>Jane Doe</i>	
16. NAME OF PHYSICIAN <i>Dr. J. Smith</i>		17. NAME OF HOSPITAL <i>St. Mary's</i>		18. NAME OF NURSE <i>Mrs. Brown</i>	
19. NAME OF CORONER <i>John Doe</i>		20. NAME OF JURY <i>None</i>		21. NAME OF JUDGE <i>None</i>	
22. NAME OF COUNTY <i>Baltimore</i>		23. NAME OF CITY <i>Baltimore</i>		24. NAME OF STATE <i>Md.</i>	
25. NAME OF COUNTY <i>Baltimore</i>		26. NAME OF CITY <i>Baltimore</i>		27. NAME OF STATE <i>Md.</i>	
28. NAME OF COUNTY <i>Baltimore</i>		29. NAME OF CITY <i>Baltimore</i>		30. NAME OF STATE <i>Md.</i>	
31. NAME OF COUNTY <i>Baltimore</i>		32. NAME OF CITY <i>Baltimore</i>		33. NAME OF STATE <i>Md.</i>	
34. NAME OF COUNTY <i>Baltimore</i>		35. NAME OF CITY <i>Baltimore</i>		36. NAME OF STATE <i>Md.</i>	
37. NAME OF COUNTY <i>Baltimore</i>		38. NAME OF CITY <i>Baltimore</i>		39. NAME OF STATE <i>Md.</i>	
40. NAME OF COUNTY <i>Baltimore</i>		41. NAME OF CITY <i>Baltimore</i>		42. NAME OF STATE <i>Md.</i>	
43. NAME OF COUNTY <i>Baltimore</i>		44. NAME OF CITY <i>Baltimore</i>		45. NAME OF STATE <i>Md.</i>	
46. NAME OF COUNTY <i>Baltimore</i>		47. NAME OF CITY <i>Baltimore</i>		48. NAME OF STATE <i>Md.</i>	
49. NAME OF COUNTY <i>Baltimore</i>		50. NAME OF CITY <i>Baltimore</i>		51. NAME OF STATE <i>Md.</i>	
52. NAME OF COUNTY <i>Baltimore</i>		53. NAME OF CITY <i>Baltimore</i>		54. NAME OF STATE <i>Md.</i>	
55. NAME OF COUNTY <i>Baltimore</i>		56. NAME OF CITY <i>Baltimore</i>		57. NAME OF STATE <i>Md.</i>	
58. NAME OF COUNTY <i>Baltimore</i>		59. NAME OF CITY <i>Baltimore</i>		60. NAME OF STATE <i>Md.</i>	
61. NAME OF COUNTY <i>Baltimore</i>		62. NAME OF CITY <i>Baltimore</i>		63. NAME OF STATE <i>Md.</i>	
64. NAME OF COUNTY <i>Baltimore</i>		65. NAME OF CITY <i>Baltimore</i>		66. NAME OF STATE <i>Md.</i>	
67. NAME OF COUNTY <i>Baltimore</i>		68. NAME OF CITY <i>Baltimore</i>		69. NAME OF STATE <i>Md.</i>	
70. NAME OF COUNTY <i>Baltimore</i>		71. NAME OF CITY <i>Baltimore</i>		72. NAME OF STATE <i>Md.</i>	
73. NAME OF COUNTY <i>Baltimore</i>		74. NAME OF CITY <i>Baltimore</i>		75. NAME OF STATE <i>Md.</i>	
76. NAME OF COUNTY <i>Baltimore</i>		77. NAME OF CITY <i>Baltimore</i>		78. NAME OF STATE <i>Md.</i>	
79. NAME OF COUNTY <i>Baltimore</i>		80. NAME OF CITY <i>Baltimore</i>		81. NAME OF STATE <i>Md.</i>	
82. NAME OF COUNTY <i>Baltimore</i>		83. NAME OF CITY <i>Baltimore</i>		84. NAME OF STATE <i>Md.</i>	
85. NAME OF COUNTY <i>Baltimore</i>		86. NAME OF CITY <i>Baltimore</i>		87. NAME OF STATE <i>Md.</i>	
88. NAME OF COUNTY <i>Baltimore</i>		89. NAME OF CITY <i>Baltimore</i>		90. NAME OF STATE <i>Md.</i>	
91. NAME OF COUNTY <i>Baltimore</i>		92. NAME OF CITY <i>Baltimore</i>		93. NAME OF STATE <i>Md.</i>	
94. NAME OF COUNTY <i>Baltimore</i>		95. NAME OF CITY <i>Baltimore</i>		96. NAME OF STATE <i>Md.</i>	
97. NAME OF COUNTY <i>Baltimore</i>		98. NAME OF CITY <i>Baltimore</i>		99. NAME OF STATE <i>Md.</i>	
100. NAME OF COUNTY <i>Baltimore</i>		101. NAME OF CITY <i>Baltimore</i>		102. NAME OF STATE <i>Md.</i>	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF BIRTH
10. OCCUPATION
11. EDUCATION
12. RELIGION
13. MARITAL STATUS
14. DATE OF MARRIAGE
15. NAME OF SPOUSE
16. NAME OF PHYSICIAN
17. NAME OF HOSPITAL
18. NAME OF NURSE
19. NAME OF CORONER
20. NAME OF JURY
21. NAME OF JUDGE
22. NAME OF COUNTY
23. NAME OF CITY
24. NAME OF STATE
25. NAME OF COUNTY
26. NAME OF CITY
27. NAME OF STATE
28. NAME OF COUNTY
29. NAME OF CITY
30. NAME OF STATE
31. NAME OF COUNTY
32. NAME OF CITY
33. NAME OF STATE
34. NAME OF COUNTY
35. NAME OF CITY
36. NAME OF STATE
37. NAME OF COUNTY
38. NAME OF CITY
39. NAME OF STATE
40. NAME OF COUNTY
41. NAME OF CITY
42. NAME OF STATE
43. NAME OF COUNTY
44. NAME OF CITY
45. NAME OF STATE
46. NAME OF COUNTY
47. NAME OF CITY
48. NAME OF STATE
49. NAME OF COUNTY
50. NAME OF CITY
51. NAME OF STATE
52. NAME OF COUNTY
53. NAME OF CITY
54. NAME OF STATE
55. NAME OF COUNTY
56. NAME OF CITY
57. NAME OF STATE
58. NAME OF COUNTY
59. NAME OF CITY
60. NAME OF STATE
61. NAME OF COUNTY
62. NAME OF CITY
63. NAME OF STATE
64. NAME OF COUNTY
65. NAME OF CITY
66. NAME OF STATE
67. NAME OF COUNTY
68. NAME OF CITY
69. NAME OF STATE
70. NAME OF COUNTY
71. NAME OF CITY
72. NAME OF STATE
73. NAME OF COUNTY
74. NAME OF CITY
75. NAME OF STATE
76. NAME OF COUNTY
77. NAME OF CITY
78. NAME OF STATE
79. NAME OF COUNTY
80. NAME OF CITY
81. NAME OF STATE
82. NAME OF COUNTY
83. NAME OF CITY
84. NAME OF STATE
85. NAME OF COUNTY
86. NAME OF CITY
87. NAME OF STATE
88. NAME OF COUNTY
89. NAME OF CITY
90. NAME OF STATE
91. NAME OF COUNTY
92. NAME OF CITY
93. NAME OF STATE
94. NAME OF COUNTY
95. NAME OF CITY
96. NAME OF STATE
97. NAME OF COUNTY
98. NAME OF CITY
99. NAME OF STATE
100. NAME OF COUNTY
101. NAME OF CITY
102. NAME OF STATE

9276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>12 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Joines</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 3, 1958</u>
9. AGE (In years last birthday) <u>NB</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newborn</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Caryle Edison Joines</u>		14. MOTHER'S MAIDEN NAME <u>Nada R. Joines/ Landreth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Congenital atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tentorial tear, right leaf</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8.3.</u> , 19 <u>58</u> , to <u>8.3.58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8.3.58</u> , 19 <u>58</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.		PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D.</u> <u>Clarksville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Linthicum Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Clarksville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>		24a. REC'D BY REGISTRAR <u>Aug 6 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

2073315XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN DEATH RECORDS

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and appears to be bleed-through from the reverse side of the page.

9277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle William Last Jones				4. DATE OF DEATH Month August Day 21 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 8, 1935	
9. AGE (In years last birthday) 23		IF UNDER 1 YEAR Months 7 Days 13		IF UNDER 24 HRS. Hours 13 Min. 13			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serv. Station Att't.				10b. KIND OF BUSINESS OR INDUSTRY Service Station			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Richard Howard Jones				14. MOTHER'S MAIDEN NAME Nancy Elizabeth Oden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-44-8176			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary hypertension DUE TO (c) Rheumatic heart disease INTERVAL BETWEEN ONSET AND DEATH 10 min. unknown 11 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 10, 1958 to August 21, 1958 , that I last saw the deceased alive on August 21, 1958 , and that death occurred at 2:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-21-58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Charles P. Brooks M.D.							
PHYSICIAN'S NAME (Type) Charles P. Brooks, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/58		22c. NAME OF CEMETERY OR CREMATORY Manassas Cemetery		22d. LOCATION (City, town, or county) (State) Manassas, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE AUG 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARIZONA—RICHMOND TO TREATMENT STATE QUALITY

•

9278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 16.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>15000 River Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>A.</u> Last <u>Joppy</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>James Calvin Wade</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Sidney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mr. William E. Smith</u>		Address <u>5000 River Road Washington 16, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO <u>581.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured Esophageal Varices</u> DUE TO <u>12 hours</u> (c) <u>Cirrhosis of Liver</u> <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>12 hours</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 Aug 58</u> , 19 <u>58</u> , to <u>14 Aug 58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Aug 58</u> , 19 <u>58</u> , and that death occurred at <u>3:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon H. Rosenblyer</u> M.D.		ADDRESS (Street, city or town, state) <u>26-N. Summit Ave</u> DATE SIGNED <u>Aug 19 58</u>	
PHYSICIAN'S NAME (Type) <u>GAITHERSBURY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Snowden</u> ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ALTHEA GLENN NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK	
		d. STREET ADDRESS 17418 BIRCH AVENUE	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle CHARLES Last KIMBALL		4. DATE OF DEATH Month AUGUST Day 3 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/84
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Dept. of Defense		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Kimball		14. MOTHER'S MAIDEN NAME Emma J. Colby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Mildred S. Kimball, 7418 Birch Ave. Takoma Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 40 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/12 , 19 57 , to 8/3 , 19 58 , that I last saw the deceased alive on 7/31 , 19 58 , and that death occurred at 4:30 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dean H. Harding		ADDRESS (Street, city or town, state) 113 Carroll St NW, Wash DC	
DATE SIGNED 8/3/58			
PHYSICIAN'S NAME (Type) DEAN H. HARDING			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/6/58	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGES COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner S. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR AUG 5 58		24b. REGISTRAR'S SIGNATURE W. S. Humphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is to be filed in the death record. Page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr Brorchart, Montgomery County
Coroner, Indigent + will
approve

Seauteroidag

CERTIFICATE OF DEATH

UNIVERSAL STATE DEPARTMENT OF HEALTH - BALTIMORE 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon 4. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G234 9/26/58

CERTIFICATE OF DEATH

9280

09265

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10012 Renfrew Road				/ d. STREET ADDRESS 10012 Renfrew Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First GIZELLA Middle KLEIN Last KLEIN				4. DATE OF DEATH Month August Day 20 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1890		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Max Grun				14. MOTHER'S MAIDEN NAME Jeanette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT William Klein Address 10012 Renfrew Road, Silver Spring			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) 5 years							INTERVAL BETWEEN ONSET AND DEATH 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent cholecystectomy (3 weeks ago)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 58 to August , 19 58 that I last saw the deceased alive on 19 Aug , 19 58 , and that death occurred at 730 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon L. Gallin				ADDRESS (Street, city or town, state) 7206 Colverville Rd			
PHYSICIAN'S NAME (Type) Leon L. Gallin MD				DATE SIGNED W. Heathwell Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 22, 1958		22c. NAME OF CEMETERY OR CREMATORY Hungarian Union Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn New York	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons				ADDRESS 3501 14th St., N.W.		24a. REC'D BY REGISTRAR DATE AUG 22 1958	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9281

CERTIFICATE OF DEATH

09266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE md b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 1641.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armon's Rest Home		d. STREET ADDRESS West St	
3. NAME OF DECEASED (Type or print) First Marie Middle Knox Last Knox		4. DATE OF DEATH Month August Day 21 Year 1958	
5. SEX female	6. COLOR OR RACE o	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 1878
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Armster E. Everen		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Otto C. Knox		Address 803 West St Laurel	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Intestinal 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis to Parotid Gland DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) c Fractured Hip (old) may have been due to malignancy			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July Aug 17 1958 , to Aug 21 1958 , that I last saw the deceased alive on August 21, 1958 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell		DATE SIGNED Aug 22 1958	
PHYSICIAN'S NAME (Type) WEBSTER SEWELL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 23/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mount Airy		22d. LOCATION (City, town, or county) (State) Prince George Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgley Selby Laurel Md		24a. REC'D BY REGISTRAR DATE AUG 25 '58	
		24b. REGISTRAR'S SIGNATURE Charles S. Hanks	

9282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3511 Napier Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Roberta Middle Gail Last Konick				4. DATE OF DEATH Month August Day 6 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 17, 1957	
9. AGE (In years lost birthday) yrs. 8 Months 20		IF UNDER 1 YEAR Days 20 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Bernard Konick				14. MOTHER'S MAIDEN NAME Rosette Sheinbein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic bronchopneumonia 754.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital heart disease DUE TO 1. Patent ductus arteriosus (c) 2. Coarctation of the aorta, infantile type 8 mo. 8 mo. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3. Valvular pulmonic stenosis 491X 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 5, 1958 to August 6, 1958 , that I last saw the deceased alive on August 6, 1958 , and that death occurred at 12:08 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 8-6-58 ACTUAL SIGNATURE Louis Gillespie, Jr. M.D. National Institutes of Health Bethesda 14, Maryland PHYSICIAN'S NAME (Type) Louis Gillespie, Jr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	
22d. LOCATION (City, town, or county) (State) Hyattsville, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons				ADDRESS 3501 14th St., N.W.		24a. REC'D BY REGISTRAR DATE AUG 11 '58	
24b. REGISTRAR'S SIGNATURE W. B. Beach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased JOHN J. HARRIS		Date of Birth 1901	
Sex Male		Race White	
Usual Residence 1111 Market Street		Date of Death August 1, 1953	
Cause of Death Myocardial Infarction		Place of Death Home	
Physician Dr. J. H. Jones		Date of Report August 5, 1953	
Signature of Physician J. H. Jones		Signature of Registrar [Signature]	
Date of Report August 5, 1953		Date of Death August 1, 1953	
Name of Deceased JOHN J. HARRIS		Date of Birth 1901	
Sex Male		Race White	
Usual Residence 1111 Market Street		Date of Death August 1, 1953	
Cause of Death Myocardial Infarction		Place of Death Home	
Physician Dr. J. H. Jones		Date of Report August 5, 1953	
Signature of Physician J. H. Jones		Signature of Registrar [Signature]	
Date of Report August 5, 1953		Date of Death August 1, 1953	

This certificate is to be used for the purpose of recording the death of a person who has died in Maryland. It is to be filled out by the physician who attended the deceased or by the coroner if the death was sudden and unexpected. It is to be signed by the physician or coroner and the registrar of the health department. It is to be filed in the office of the registrar of the health department. It is to be used for the purpose of recording the death of a person who has died in Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's stamp. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9283

CERTIFICATE OF DEATH

09268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>	
c. LENGTH OF STAY IN AB <u>13 months</u>		d. STREET ADDRESS <u>4844 Chevy Chase Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4844 Chevy Chase Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rudolph</u> Middle <u>Larsen</u> Last <u>Larsen</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 29, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Niels Larsen</u>		14. MOTHER'S MAIDEN NAME <u>Karen Peterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wife (Mrs. Anna Larsen)</u>		Address <u>see 2d.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia (slightly progressive for acute)</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia and heart failure</u> DUE TO (c) <u>Parkinsonism - hyperthyroidism</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493 Prostatic hypertrophy</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u> <u>6 months</u> <u>6 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/2</u> , 19 <u>57</u> , to <u>8/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/12</u> , 19 <u>58</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Allen J. O'Neill</u>		ADDRESS (Street, city or town, state) <u>8601 old Beagetown Rd Bethesda Md</u>	
DATE SIGNED <u></u>		DATE SIGNED <u></u>	
PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u>		DATE SIGNED <u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>8/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Farwell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Farwell, Nebraska</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hyatt</u>	

CERTIFICATE OF DEATH

3283

Date of Death 1900		Place of Death Baltimore, Maryland	
Name of Deceased John Doe		Sex Male	
Age 45		Race White	
Date of Birth 1855		Place of Birth Baltimore, Maryland	
Cause of Death Heart Disease		Manner of Death Natural	
Physician's Name Dr. J. Smith		Burial Place St. Mary's Cemetery	
Signature of Physician J. Smith		Signature of Registrar J. Doe	



This certificate is to be filled out by the physician attending the deceased, or by the coroner, or by the registrar of the health department, or by the undertaker, or by the family of the deceased, or by any other person who may be authorized by the health department to fill out this certificate. It is to be filled out in duplicate, one copy to be retained by the health department, and the other copy to be retained by the family of the deceased, or by the undertaker, or by the registrar of the health department, or by the coroner, or by the physician attending the deceased.

CERTIFICATE OF DEATH

09269

Reg. Dist. No.

9187

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>2021 - 38th St., S.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nettie</u> First <u>Clarissa</u> Middle <u>Lawson</u> Last		4. DATE OF DEATH <u>August 17</u> 19 <u>58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21-1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Mann Martin</u>		14. MOTHER'S MAIDEN NAME <u>Solia Nightingale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure, acute</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> (c) <u>aged</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 15, 1958</u> to <u>Aug 17, 1958</u> , that I last saw the deceased alive on <u>Aug 16, 1958</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. F. Thibadeau</u>		ADDRESS (Street, city or town, state) <u>10111 Colasville Rd.</u>	
PHYSICIAN'S NAME (Type) <u>A F THIB</u>		DATE SIGNED <u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-58</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill</u>		22d. LOCATION (City, town or county) (State) <u>Switland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Chambers</u>		ADDRESS <u>1400 Chapin St.</u>	
24a. REC'D BY REGISTRAR <u>AUG 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9284

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 22 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Lewisberry c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75x-3 d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Henry Lecrone				4. DATE OF DEATH Month Day Year August 29, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 4, 1917	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Selling	
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Anthony J. Lecrone				14. MOTHER'S MAIDEN NAME Hattie A. Frey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or date of service) WW II 205-10-2847		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Obstruction 197.2 DUE TO Metastatic Sarcoma of the Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Rhabdomyosarcoma of right Arm (b) (c) INTERVAL BETWEEN ONSET AND DEATH 48 hours 4 months 15 months						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 7, 1958 , to August 29, 1958 , that I last saw the deceased alive on August 29, 1958 , and that death occurred at 5:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Nathan S. Taylor		M.D. NATHAN S. TAYLOR, M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 8/29/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/58		22c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery		22d. LOCATION (City, town, or county) (State) Springettsbury Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS 7557 Wisc Ave Beth Md		24a. REC'D BY REGISTRAR DATE SEP 2 1958	
				24b. REGISTRAR'S SIGNATURE Arthur S. K...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09271

9285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>Clark</u> Last <u>Leffingwell</u>		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1866</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vermont</u>	
11. BIRTHPLACE (State or foreign country) <u>America</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Dyar Leffingwell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Saunders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Thomas Cullen Leffingwell</u>		Address <u>4011 Spruell Drive Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-4</u> , 19 <u>58</u> , to <u>Aug 25</u> , 19 <u>58</u> . That I last saw the deceased alive on <u>Aug 24</u> , 19 <u>58</u> , and that death occurred at <u>7:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u>		DATE SIGNED <u>8/25/58</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		ADDRESS (Street, city or town, state) <u>10511 Summit Ave Kensington, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u>AUG 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Grand</u>	

CERTIFICATE OF DEATH

Reg. Dist. No. 09272

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs 56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8716 Leonard Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Anthony</u> Last <u>Livingston</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u> <u>Oct. 27, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Buyer</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Livingston</u>		14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ms. Sadie Livingston - Same</u>	
17. INFORMANT <u>Ms. Sadie Livingston</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>7 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> , to <u>Present</u> , that I last saw the deceased alive on <u>Aug. 2</u> , 19 <u>58</u> , and that death occurred at <u>8:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arnold B. Gordon</u>		DATE SIGNED <u>2875 - Conn. Ave. N.W. Wash. D.C. 8/3/58</u>	
PHYSICIAN'S NAME (Type) <u>A.B. GORDON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belmont-Burial</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Johnson & Son Inc. 1124-26 W. North Ave.</u>		24a. REC'D BY REGISTRAR <u>Aug 5 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

Reg. Dist. No. 215

1. PLACE OF BIRTH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 60 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill		70x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNM, Bethesda, Md.				d. STREET ADDRESS Post Office Box 897		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Donald		First Wood		Middle LOOMIS		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 July 1895	
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Fred Wood LOOMIS				14. MOTHER'S MAIDEN NAME Jane GOSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I and WW-II		17. INFORMANT (Wife) Mrs. Esther Y. LOOMIS (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis Pneumonia 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO (c) Carcinoma Lung						INTERVAL BETWEEN ONSET AND DEATH 3 days 18 mos. 18 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 June , 19 58 , to 4 August , 19 58 , that I last saw the deceased alive on 4 August , 19 58 , and that death occurred at 1:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-4-58 ACTUAL SIGNATURE T. S. DUNN, JR. M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) T. S. DUNN, JR. LT MC USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6 August 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md. 1557 Wisconsin Ave.		24a. REC'D BY REGISTRAR DATE AUG 6 '58	
				24b. REGISTRAR'S SIGNATURE W. L. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>	
c. LENGTH OF STAY IN 1b <u>12 days</u>		d. STREET ADDRESS <u>105 E. Franklin Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ovide</u> Middle <u>Arthur</u> Last <u>Lussier</u>		4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-00</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Typist, Nat'l. Institute of Health</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rhode Island</u>	
11. BIRTHPLACE (State or foreign country) <u>America</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Joseph E. Lussier</u>		14. MOTHER'S MAIDEN NAME <u>Nadeau</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-10-9006</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> <u>572.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive retro peritoneal abscess right side</u> DUE TO (c) <u>Diverticulitis right colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 5</u> , 19 <u>58</u> , to <u>Aug 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u>		ADDRESS (Street, city or town, state) <u>217 University Blvd E. S.S.</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		DATE SIGNED <u>8-11-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BURTONSVILLE, MONTGOMERY CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>AUG 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hand</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon portion of the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JUDGE		14. SIGNATURE OF CLERK		15. SIGNATURE OF SHERIFF	
16. SIGNATURE OF DEPUTY SHERIFF		17. SIGNATURE OF CONSTABLE		18. SIGNATURE OF JURY	
19. SIGNATURE OF GRAND JURY		20. SIGNATURE OF COURT		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF	
25. SIGNATURE OF CONSTABLE		26. SIGNATURE OF JURY		27. SIGNATURE OF GRAND JURY	
28. SIGNATURE OF COURT		29. SIGNATURE OF JUDGE		30. SIGNATURE OF CLERK	
31. SIGNATURE OF SHERIFF		32. SIGNATURE OF DEPUTY SHERIFF		33. SIGNATURE OF CONSTABLE	
34. SIGNATURE OF JURY		35. SIGNATURE OF GRAND JURY		36. SIGNATURE OF COURT	
37. SIGNATURE OF JUDGE		38. SIGNATURE OF CLERK		39. SIGNATURE OF SHERIFF	
40. SIGNATURE OF DEPUTY SHERIFF		41. SIGNATURE OF CONSTABLE		42. SIGNATURE OF JURY	
43. SIGNATURE OF GRAND JURY		44. SIGNATURE OF COURT		45. SIGNATURE OF JUDGE	
46. SIGNATURE OF CLERK		47. SIGNATURE OF SHERIFF		48. SIGNATURE OF DEPUTY SHERIFF	
49. SIGNATURE OF CONSTABLE		50. SIGNATURE OF JURY		51. SIGNATURE OF GRAND JURY	
52. SIGNATURE OF COURT		53. SIGNATURE OF JUDGE		54. SIGNATURE OF CLERK	
55. SIGNATURE OF SHERIFF		56. SIGNATURE OF DEPUTY SHERIFF		57. SIGNATURE OF CONSTABLE	
58. SIGNATURE OF JURY		59. SIGNATURE OF GRAND JURY		60. SIGNATURE OF COURT	
61. SIGNATURE OF JUDGE		62. SIGNATURE OF CLERK		63. SIGNATURE OF SHERIFF	
64. SIGNATURE OF DEPUTY SHERIFF		65. SIGNATURE OF CONSTABLE		66. SIGNATURE OF JURY	
67. SIGNATURE OF GRAND JURY		68. SIGNATURE OF COURT		69. SIGNATURE OF JUDGE	
70. SIGNATURE OF CLERK		71. SIGNATURE OF SHERIFF		72. SIGNATURE OF DEPUTY SHERIFF	
73. SIGNATURE OF CONSTABLE		74. SIGNATURE OF JURY		75. SIGNATURE OF GRAND JURY	
76. SIGNATURE OF COURT		77. SIGNATURE OF JUDGE		78. SIGNATURE OF CLERK	
79. SIGNATURE OF SHERIFF		80. SIGNATURE OF DEPUTY SHERIFF		81. SIGNATURE OF CONSTABLE	
82. SIGNATURE OF JURY		83. SIGNATURE OF GRAND JURY		84. SIGNATURE OF COURT	
85. SIGNATURE OF JUDGE		86. SIGNATURE OF CLERK		87. SIGNATURE OF SHERIFF	
88. SIGNATURE OF DEPUTY SHERIFF		89. SIGNATURE OF CONSTABLE		90. SIGNATURE OF JURY	
91. SIGNATURE OF GRAND JURY		92. SIGNATURE OF COURT		93. SIGNATURE OF JUDGE	
94. SIGNATURE OF CLERK		95. SIGNATURE OF SHERIFF		96. SIGNATURE OF DEPUTY SHERIFF	
97. SIGNATURE OF CONSTABLE		98. SIGNATURE OF JURY		99. SIGNATURE OF GRAND JURY	
100. SIGNATURE OF COURT		101. SIGNATURE OF JUDGE		102. SIGNATURE OF CLERK	
103. SIGNATURE OF SHERIFF		104. SIGNATURE OF DEPUTY SHERIFF		105. SIGNATURE OF CONSTABLE	
106. SIGNATURE OF JURY		107. SIGNATURE OF GRAND JURY		108. SIGNATURE OF COURT	
109. SIGNATURE OF JUDGE		110. SIGNATURE OF CLERK		111. SIGNATURE OF SHERIFF	
112. SIGNATURE OF DEPUTY SHERIFF		113. SIGNATURE OF CONSTABLE		114. SIGNATURE OF JURY	
115. SIGNATURE OF GRAND JURY		116. SIGNATURE OF COURT		117. SIGNATURE OF JUDGE	
118. SIGNATURE OF CLERK		119. SIGNATURE OF SHERIFF		120. SIGNATURE OF DEPUTY SHERIFF	
121. SIGNATURE OF CONSTABLE		122. SIGNATURE OF JURY		123. SIGNATURE OF GRAND JURY	
124. SIGNATURE OF COURT		125. SIGNATURE OF JUDGE		126. SIGNATURE OF CLERK	
127. SIGNATURE OF SHERIFF		128. SIGNATURE OF DEPUTY SHERIFF		129. SIGNATURE OF CONSTABLE	
130. SIGNATURE OF JURY		131. SIGNATURE OF GRAND JURY		132. SIGNATURE OF COURT	
133. SIGNATURE OF JUDGE		134. SIGNATURE OF CLERK		135. SIGNATURE OF SHERIFF	
136. SIGNATURE OF DEPUTY SHERIFF		137. SIGNATURE OF CONSTABLE		138. SIGNATURE OF JURY	
139. SIGNATURE OF GRAND JURY		140. SIGNATURE OF COURT		141. SIGNATURE OF JUDGE	
142. SIGNATURE OF CLERK		143. SIGNATURE OF SHERIFF		144. SIGNATURE OF DEPUTY SHERIFF	
145. SIGNATURE OF CONSTABLE		146. SIGNATURE OF JURY		147. SIGNATURE OF GRAND JURY	
148. SIGNATURE OF COURT		149. SIGNATURE OF JUDGE		150. SIGNATURE OF CLERK	
151. SIGNATURE OF SHERIFF		152. SIGNATURE OF DEPUTY SHERIFF		153. SIGNATURE OF CONSTABLE	
154. SIGNATURE OF JURY		155. SIGNATURE OF GRAND JURY		156. SIGNATURE OF COURT	
157. SIGNATURE OF JUDGE		158. SIGNATURE OF CLERK		159. SIGNATURE OF SHERIFF	
160. SIGNATURE OF DEPUTY SHERIFF		161. SIGNATURE OF CONSTABLE		162. SIGNATURE OF JURY	
163. SIGNATURE OF GRAND JURY		164. SIGNATURE OF COURT		165. SIGNATURE OF JUDGE	
166. SIGNATURE OF CLERK		167. SIGNATURE OF SHERIFF		168. SIGNATURE OF DEPUTY SHERIFF	
169. SIGNATURE OF CONSTABLE		170. SIGNATURE OF JURY		171. SIGNATURE OF GRAND JURY	
172. SIGNATURE OF COURT		173. SIGNATURE OF JUDGE		174. SIGNATURE OF CLERK	
175. SIGNATURE OF SHERIFF		176. SIGNATURE OF DEPUTY SHERIFF		177. SIGNATURE OF CONSTABLE	
178. SIGNATURE OF JURY		179. SIGNATURE OF GRAND JURY		180. SIGNATURE OF COURT	
181. SIGNATURE OF JUDGE		182. SIGNATURE OF CLERK		183. SIGNATURE OF SHERIFF	
184. SIGNATURE OF DEPUTY SHERIFF		185. SIGNATURE OF CONSTABLE		186. SIGNATURE OF JURY	
187. SIGNATURE OF GRAND JURY		188. SIGNATURE OF COURT		189. SIGNATURE OF JUDGE	
190. SIGNATURE OF CLERK		191. SIGNATURE OF SHERIFF		192. SIGNATURE OF DEPUTY SHERIFF	
193. SIGNATURE OF CONSTABLE		194. SIGNATURE OF JURY		195. SIGNATURE OF GRAND JURY	
196. SIGNATURE OF COURT		197. SIGNATURE OF JUDGE		198. SIGNATURE OF CLERK	
199. SIGNATURE OF SHERIFF		200. SIGNATURE OF DEPUTY SHERIFF		201. SIGNATURE OF CONSTABLE	
202. SIGNATURE OF JURY		203. SIGNATURE OF GRAND JURY		204. SIGNATURE OF COURT	
205. SIGNATURE OF JUDGE		206. SIGNATURE OF CLERK		207. SIGNATURE OF SHERIFF	
208. SIGNATURE OF DEPUTY SHERIFF		209. SIGNATURE OF CONSTABLE		210. SIGNATURE OF JURY	
211. SIGNATURE OF GRAND JURY		212. SIGNATURE OF COURT		213. SIGNATURE OF JUDGE	
214. SIGNATURE OF CLERK		215. SIGNATURE OF SHERIFF		216. SIGNATURE OF DEPUTY SHERIFF	
217. SIGNATURE OF CONSTABLE		218. SIGNATURE OF JURY		219. SIGNATURE OF GRAND JURY	
220. SIGNATURE OF COURT		221. SIGNATURE OF JUDGE		222. SIGNATURE OF CLERK	
223. SIGNATURE OF SHERIFF		224. SIGNATURE OF DEPUTY SHERIFF		225. SIGNATURE OF CONSTABLE	
226. SIGNATURE OF JURY		227. SIGNATURE OF GRAND JURY		228. SIGNATURE OF COURT	
229. SIGNATURE OF JUDGE		230. SIGNATURE OF CLERK		231. SIGNATURE OF SHERIFF	
232. SIGNATURE OF DEPUTY SHERIFF		233. SIGNATURE OF CONSTABLE		234. SIGNATURE OF JURY	
235. SIGNATURE OF GRAND JURY		236. SIGNATURE OF COURT		237. SIGNATURE OF JUDGE	
238. SIGNATURE OF CLERK		239. SIGNATURE OF SHERIFF		240. SIGNATURE OF DEPUTY SHERIFF	
241. SIGNATURE OF CONSTABLE		242. SIGNATURE OF JURY		243. SIGNATURE OF GRAND JURY	
244. SIGNATURE OF COURT		245. SIGNATURE OF JUDGE		246. SIGNATURE OF CLERK	
247. SIGNATURE OF SHERIFF		248. SIGNATURE OF DEPUTY SHERIFF		249. SIGNATURE OF CONSTABLE	
250. SIGNATURE OF JURY		251. SIGNATURE OF GRAND JURY		252. SIGNATURE OF COURT	
253. SIGNATURE OF JUDGE		254. SIGNATURE OF CLERK		255. SIGNATURE OF SHERIFF	
256. SIGNATURE OF DEPUTY SHERIFF		257. SIGNATURE OF CONSTABLE		258. SIGNATURE OF JURY	
259. SIGNATURE OF GRAND JURY		260. SIGNATURE OF COURT		261. SIGNATURE OF JUDGE	
262. SIGNATURE OF CLERK		263. SIGNATURE OF SHERIFF		264. SIGNATURE OF DEPUTY SHERIFF	
265. SIGNATURE OF CONSTABLE		266. SIGNATURE OF JURY		267. SIGNATURE OF GRAND JURY	
268. SIGNATURE OF COURT		269. SIGNATURE OF JUDGE		270. SIGNATURE OF CLERK	
271. SIGNATURE OF SHERIFF		272. SIGNATURE OF DEPUTY SHERIFF		273. SIGNATURE OF CONSTABLE	
274. SIGNATURE OF JURY		275. SIGNATURE OF GRAND JURY		276. SIGNATURE OF COURT	
277. SIGNATURE OF JUDGE		278. SIGNATURE OF CLERK		279. SIGNATURE OF SHERIFF	
280. SIGNATURE OF DEPUTY SHERIFF		281. SIGNATURE OF CONSTABLE		282. SIGNATURE OF JURY	
283. SIGNATURE OF GRAND JURY		284. SIGNATURE OF COURT		285. SIGNATURE OF JUDGE	
286. SIGNATURE OF CLERK		287. SIGNATURE OF SHERIFF		288. SIGNATURE OF DEPUTY SHERIFF	
289. SIGNATURE OF CONSTABLE		290. SIGNATURE OF JURY		291. SIGNATURE OF GRAND JURY	
292. SIGNATURE OF COURT		293. SIGNATURE OF JUDGE		294. SIGNATURE OF CLERK	
295. SIGNATURE OF SHERIFF		296. SIGNATURE OF DEPUTY SHERIFF		297. SIGNATURE OF CONSTABLE	
298. SIGNATURE OF JURY		299. SIGNATURE OF GRAND JURY		300. SIGNATURE OF COURT	

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9000 Flower Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Oscar Marks</u>		4. DATE OF DEATH <u>Aug 25 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Marks</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Frederick J. Sellers</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombosis hemorrhage</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wound Thru left chest (heart)</u> (c) <u>due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound Thru chest</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:02 P.M. 8-25-1958</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Silver Spring Montg</u> (County) <u>md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-25-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 27, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Font Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Prince George's Co., Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09276

9289

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY 85x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 348 Lincoln Street	
3. NAME OF DECEASED (Type or print) First Benigno Middle (none) Last Martinez		4. DATE OF DEATH Month August Day 25 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 15, 1898
9. AGE (In years lost birthday) yrs. 60		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Spain		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francisco Martinez		14. MOTHER'S MAIDEN NAME Marie Alverrez	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes VV II		16. SOCIAL SECURITY NO. 234-01-1547	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myelogenous Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 Year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 1958 , to August 25, 1958 , that I last saw the deceased alive on August 25, 1958 , and that death occurred at 9:10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Roger Lester		DATE SIGNED 8/26/58	
PHYSICIAN'S NAME (Type) ROGER LESTER, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 8/29/58	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Fairmont, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR AUG 27 58 DATE	
24b. REGISTRAR'S SIGNATURE John S. Howard			

9290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 172 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worthington, 85 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS P.O. Box 305		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Nelle Middle Madaline Last Mason			4. DATE OF DEATH Month August Day 20 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1910		9. AGE (In years last birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior decorating inspector - Factory		10b. KIND OF BUSINESS OR INDUSTRY West Virginia		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Charles Mason			14. MOTHER'S MAIDEN NAME Eliza Matthews		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic broncho-pneumonia 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the breast with widespread metastases to bone and liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic incomplete intestinal obstruction with ulceration of					INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 4 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) stomach & duodenum	
21. I certify that I attended the deceased from March 1, 1958 , to August 20, 1958 , that I last saw the deceased alive on August 20, 1958 , and that death occurred at 1:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-20-58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland					
ACTUAL SIGNATURE Richard H. Moy		M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Richard H. Moy, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/58		22c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	
22d. LOCATION (City, town, or county) (State) Shinnston, West Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland			ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE AUG 22 '58
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon parts. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Box 304

2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9291 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09278

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		c. LENGTH OF STAY IN lb 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 25605 Ridge Rd			d. STREET ADDRESS 25605 Ridge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Irving Maurice Matney			4. DATE OF DEATH Aug. 30 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/1908		9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY N.I.H.		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME Floyd S. Matney		
14. MOTHER'S MAIDEN NAME Evelyn Yates			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. # 2		
16. SOCIAL SECURITY NO. 228-03-0668			17. INFORMANT Mrs. Pearl Matney Address Item 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/30/58	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
22d. LOCATION (City, town, or county) (State) Frederick, Md.		24a. REC'D BY REGISTRAR DATE SEP 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE Chas J. Wolsworth		ADDRESS Damascus, Md.			

MARYLAND STATE DEPARTMENT OF STATE—BALTIMORE, 18
9292
CERTIFICATE OF DEATH

09279

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boothsda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillindale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Cresthaven Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Arthur</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 9 1910</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Matthews</u>				14. MOTHER'S MAIDEN NAME <u>Emma Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sister Hattie B. Jackson</u>		Address <u>1117 Fairland Collesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophago-Tracheal fistula</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>secondary to esophageal carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that I attended the deceased from <u>7-15</u> , 19 <u>58</u> , to <u>8-7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-7</u> , 19 <u>58</u> , and that death occurred at <u>9:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Robert R. Asenbarger</u> M.D. <u>26 N. Summit Ave. Rockville, Md.</u> PHYSICIAN'S NAME (Type) <u>Robert R. Asenbarger</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope.</u>	22d. LOCATION (City, town, or county) <u>Colesville, Md.</u> (State) _____				
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.L. SNOWDEN</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Tracy</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>13X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS <u>Woodland Road</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>SYKES</u> Last <u>MAY</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-30-1870</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw Mill Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>Isaac H. May</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Hevner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Ira Delawder, Ellicott City, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerotic heart disease & chronic myocardial failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 16, 1958</u> , to <u>Aug. 21, 1958</u> , that I last saw the deceased alive on <u>Aug. 21, 1958</u> , and that death occurred at <u>7.00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u>				ADDRESS (Street, city or town, state) <u>Clarksville, Md.</u> DATE SIGNED <u>8-22-58</u>			
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker M.D.</u>				<u>Clarksville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 25 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9294

CERTIFICATE OF DEATH

09281

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1610 NEELEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Silver Spring</u>		d. STREET ADDRESS <u>1610 NEELEY</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN HENRY Mc KAY</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 4, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen'l Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Mc Kay</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lang</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-5112</u>	
17. INFORMANT <u>Mrs Elizabeth Mc Kay - wife</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO-SCLEROTIC cerebral</u> DUE TO <u>Vascular Disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 mos +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arterio-sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u>19</u> Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 17, 1958</u> , to <u>AUG 8, 1958</u> , that I last saw the deceased alive on <u>AUG 8, 1958</u> , and that death occurred at <u>10:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wolcott L. Etienne</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4713-BERYN RD 8/8/58</u>	
PHYSICIAN'S NAME (Type) <u>WOLCOTT L. ETIENNE</u>		<u>COLLEGE PARK, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/12/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner S. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9295

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck				c. LENGTH OF STAY IN 1b 1 yr 8 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Philomena Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET ELLEN Mc NAMARA				4. DATE OF DEATH Month Day Year August 30, 19 58-			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 25, 1871	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Pittsburg Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Patrick Mc Linden				14. MOTHER'S MAIDEN NAME Margaret E ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Thomas E Mc Namara Kent Village Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) A.S.C.V.D						INTERVAL BETWEEN ONSET AND DEATH 3 weeks years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 492X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 30, 19 58 , to Aug 30, 19 58 , that I last saw the deceased alive on Aug 29, 19 58 , and that death occurred at 12600 FARLAND Drive Rockville, Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles M Weber				DATE SIGNED 12600 FARLAND Drive Rockville, Md.			
PHYSICIAN'S NAME (Type) Charles M Weber				Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Old Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Greenpoint Brooklyn New York.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE SEP 2 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• • •

3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09283

Items 4, 10b & 11, Film G-233 9/2/58, cag.

9296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Resmore San't Hosp</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmore Rest Home</u>				d. STREET ADDRESS <u>4317 Maple Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Mellor</u> Last <u>Mellor</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 25, 1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>22</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland/ England</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Bookkeeping</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Joseph Mellor</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>094-10-8529</u>		17. INFORMANT <u>Mary S. Mellor - Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure -</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemorrhage from Urinary Bladder -</u> DUE TO (c) <u>Metastatic Carcinoma of Bladder Prostate & Penis -</u> <u>6 Mo -</u>				INTERVAL BETWEEN ONSET AND DEATH. <u>24 hr.</u> <u>48 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Sigmoid - Removed - 1955. C.V. Disease & Hemiplegia.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>date</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>17th Aug.</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7936 Old Georgetown Rd. Bethesda, Md.</u>				DATE SIGNED <u>8/16/58</u>			
ACTUAL SIGNATURE <u>John G. Ball</u>				M.D. <u>7936 Old Georgetown Rd. Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>				<u>7936 Old Georgetown Rd. Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 19 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert L. Pumphrey</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME Robert J. Murphy		SEX Male		AGE 41	
RACE White		BIRTH 1914		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Unknown		CAUSE OF DEATH Unknown		MANNER OF DEATH Unknown	
DATE OF DEATH August 16, 1955		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (If known)		SIGNATURE OF PHYSICIAN (If known)	
SIGNATURE OF REGISTRAR (If known)		SIGNATURE OF CLERK (If known)		SIGNATURE OF JUDGE (If known)	

9297

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>7518 9th St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>(nmn)</u> Last <u>MESTESKY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 12, 1904</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy, (Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Julius Metesky</u>		14. MOTHER'S MAIDEN NAME <u>Ida (Last Name Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Official Navy Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>16 August</u> , 19 <u>58</u> to <u>17 August</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>17 August</u> , 19 <u>58</u> , and that death occurred at <u>8:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. E. Gorsuch</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>G. E. GORSUCH, LT, MC, USN</u>		DATE SIGNED <u>8-18-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzanski & Sons</u>		24a. REC'D BY REGISTRAR <u>AUG 19 '58</u>	
ADDRESS <u>Danzanski, 8501 14th St., Washington, D. C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DECEASED'S NAME

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

(Manner)

DECEASED'S AGE

SEX

DECEASED'S OCCUPATION

DECEASED'S MARITAL STATUS

DECEASED'S RELIGION

DECEASED'S RACE

DECEASED'S ETHNICITY

DECEASED'S EDUCATION

DECEASED'S SERVICE

DECEASED'S SOCIAL SECURITY NUMBER

DECEASED'S VOTER REGISTRATION

DECEASED'S HEALTH INSURANCE

DECEASED'S LIFE INSURANCE

DECEASED'S AUTO INSURANCE

DECEASED'S HOMEOWNERS INSURANCE

DECEASED'S FIRE INSURANCE

DECEASED'S FLOOD INSURANCE

DECEASED'S TERRORISM INSURANCE

DECEASED'S OTHER INSURANCE

DECEASED'S OTHER INFORMATION

DECEASED'S OTHER COMMENTS

DECEASED'S OTHER NOTES

DECEASED'S OTHER RECORDS

DECEASED'S OTHER FILES

DECEASED'S OTHER DOCUMENTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1
4
M
50
I
2
1
REP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9298
CERTIFICATE OF DEATH

09285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethelwyn</u> Middle <u>Irene</u> Last <u>Meyer</u>		4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1909</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>49</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward S. Hine</u>		14. MOTHER'S MAIDEN NAME <u>Ethelwyn A. Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unascertainable</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>204.2</u> IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> DUE TO <u>1</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. <u>Acute Myloblastic leukemia</u> DUE TO (b) <u>3 Weeks</u> (c) <u>3 Weeks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 8, 1958</u> , to <u>August 8, 1958</u> , that I last saw the deceased alive on <u>August 8, 1958</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Richard Lee MD</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>8/9/58</u>	
PHYSICIAN'S NAME (Type) <u>G. RICHARD LEE, M.D.</u>		<u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pearson Funeral Home</u> <u>Rm Jackson</u>		24a. REC'D BY REGISTRAR <u>Falls Church Va</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krouse</u>		DATE <u>AUG 12 1958</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09286

9189

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>12 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. STREET ADDRESS <u>1808 West Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>James</u> Last <u>Minchin</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-58</u>	9. AGE (In years last birthday) yrs. _____	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>36</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Kelvin Lennard Minchin</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Joan Lonergan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother's chart</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity, Pulmonary atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral congestion & edema</u> (secondary) DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>8-24</u> , 19 <u>58</u> , to <u>8-24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-24</u> 19 <u>58</u> , and that death occurred at <u>3:13</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Emma Hughes</u> M.D. <u>Takoma Park, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Emma Hughes, M.D. Washington Sanitarium & Hospital, Takoma Park, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8-27-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park 12, Md</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. [unclear]</u> Washington San. & Hosp.				24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>	

2075233XV2

CERTIFICATE OF DEATH

9189

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES M. BROWN		M		45		JAN 15 1918	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
HOME		HEART DISEASE		NATURAL		LABORER	
RESIDENCE		HUSBAND OF		BORN		DATE OF BIRTH	
BALTIMORE, MD.		JANE BROWN		JAN 15 1873		JAN 15 1873	
EDUCATION		RELIGION		SIGNED BY		DATE	
HIGH SCHOOL		METHODIST		J. B. SMITH		JAN 15 1918	
PREVIOUS ILLNESS		TREATMENT		TESTED BY		DATE	
NONE		NONE		J. B. SMITH		JAN 15 1918	
BURIAL PLACE		CITY		COUNTY		STATE	
GREENWOOD CEMETERY		BALTIMORE		BALTIMORE		MD.	
INTERVIEWED BY		DATE		SIGNED BY		DATE	
J. B. SMITH		JAN 15 1918		J. B. SMITH		JAN 15 1918	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF REGISTERING THE DEATH OF THE DECEASED ONLY. IT DOES NOT CONSTITUTE A GUARANTEE OF THE ACCURACY OF THE INFORMATION CONTAINED HEREIN. THE STATE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE CONSEQUENCES OF ANY ACTION OR INACTION TAKEN BY ANY PERSON OR ENTITY BASED ON THIS CERTIFICATE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9299

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4028 8th Street, N. E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Daniel Leo Moriarty		4. DATE OF DEATH Month Day Year August 4 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1904
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secret Service Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Moriarty		14. MOTHER'S MAIDEN NAME Julia Hogan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? Hepatic Coma 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis, Liver - severe DUE TO (c) Acute Myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH 1-wk yes 1-2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22 19 58 , to August 4, 1958 , that I last saw the deceased alive on August 4, 19 58 , and that death occurred at 5:20AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 8/4/58 National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-5-58	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) St. Paul, Minn.	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Harlow Jr. Done		24a. REC'D BY REGISTRAR DATE AUG 6 '58	
24b. REGISTRAR'S SIGNATURE W. H. D. C.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09288

9201

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4604 Bayne Ct.</u>				d. STREET ADDRESS <u>1 4604 Bayne Ct</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Elizabeth Morris</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-3-126</u>	9. AGE (In years last birthday) <u>31</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>W.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Edw. L. Humphries</u>				14. MOTHER'S MAIDEN NAME <u>Marquette Bayne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-32-6536</u>		17. INFORMANT <u>Theresa Morris - same as decd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>345X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Multiple Sclerosis</u> (c) <u>Multiple Sclerosis</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Interval between onset and death</u> <u>Found dead in bed</u> <u>6 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u> <u>6 yrs</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Buschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BUSCHERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-25-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Pumphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1001

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1002

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, 3 should be used as a burial-transit permit. File pages 1, 2, 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park - Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington 16 DC</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leland</u> First <u>Wayne</u> Middle <u>Morrow</u> Last		DATE OF DEATH <u>Aug 4 1958</u> Month <u>Aug</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah H. Morrow</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Duddleson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>6500 Winifred Rd Bethesda 14, Md</u>	
17. INFORMANT <u>Mrs. Lorin Shanks</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> DUE TO <u>Coronary occlusion</u> (a), stating the underlying cause last. (c) <u>420.1</u> DUE TO <u>Coronary occlusion</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 4 1958</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Ford</u>		ADDRESS <u>515 3rd St. N.W. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Aug 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

FOR STATE
HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

IMPRINTED
BOND

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Milma232 8/15/58 001

09290

CERTIFICATE OF DEATH

Reg. Dist. No.

9301

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Germantown Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander		d. STREET ADDRESS 1644 Wisconsin Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle E. Last MOYER		4. DATE OF DEATH Month August Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 9 Days 15 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ambrose Moyer		14. MOTHER'S MAIDEN NAME Elizabeth Stombock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Marylander Records		Address Germantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 years DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 21, 1957 to August 2, 1958 , that I last saw the deceased alive on July 31, 1958 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Maryland DATE SIGNED 8-2-58			
ACTUAL SIGNATURE JAMES P. KERR		PHYSICIAN'S NAME (Type) JAMES P. KERR	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-58	22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery
22d. LOCATION (City, town, or county) (State) Montgomery County, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR AUG 5 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

NAME OF DECEASED		MARRIAGE		EDUCATION	
JAMES M. JONES		MARRIED		HIGH SCHOOL	
AGE		SEX		RACE	
35		Male		White	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF RESIDENCE	
Jan 15, 1866		Baltimore, Md.		Baltimore, Md.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Clerk		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Jan 20, 1901		Baltimore, Md.		Baltimore, Md.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER	
J. M. Jones		J. M. Jones		J. M. Jones	
DATE		PLACE		CITY	
Jan 20, 1901		Baltimore, Md.		Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

9302 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09291

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Queens	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 29 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City - Forrest Hills 69x-3		d. STREET ADDRESS 109-15 Queens Boulevard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Frank Last NOLAN		4. DATE OF DEATH Month August Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-93
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank H. NOLAN		14. MOTHER'S MAIDEN NAME Elizabeth J. SAUNDERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 060-07-3259	
17. INFORMANT Mrs. Rae F. Nolan (wife), same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinomatosis 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Primary site probably pancreas) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10 , 19 58 , to August 8 , 19 58 , that I last saw the deceased alive on August 8 , 19 58 , and that death occurred at 7:47P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. E. MC CLENATHAN		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 8-9-58	
PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-13-58	
22c. NAME OF CEMETERY OR CREMATORY Northwood Cemetery		22d. LOCATION (City, town, or county) (State) No. Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 1400 Chapin St., N.W.		24a. REC'D BY REGISTRAR AUG 12 1958	
ADDRESS Washington, DC		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and taken to the funeral home as the burial-transit permit. Then please remove carbon paper and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09292

9190

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		d. STREET ADDRESS <u>1509 Dublin Dr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>OWENS</u>		4. DATE OF DEATH Month <u>8-3</u> Day <u>58</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-58</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>USA - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rome Roy Owens</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Nell Kniedy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>mother's Chart</u>	
17. INFORMANT <u>mother's Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EDEMA + HYPEREMIA</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-3</u> , 19 <u>58</u> , to <u>8-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-3</u> , 19 <u>58</u> , and that death occurred at <u>7:05 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.B. Snow</u>		ADDRESS (Street, city or town, state) <u>9013 Flower Ave</u>	
PHYSICIAN'S NAME (Type) <u>L. B. Snow, M.D.</u>		DATE SIGNED <u>8/3/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8-5-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare</u>		24a. REC'D BY REGISTRAR <u>W. L. Leach</u>	
ADDRESS <u>Robert A. Hare, M.D., Washington San. & Hosp.</u>		DATE <u>AUG 8 '58</u>	

2075322XVV

9303

CERTIFICATE OF DEATH

09293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 29 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2109 HANOVER STREET				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS 2109 HANOVER STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELSIE C. PENICKS				4. DATE OF DEATH AUGUST 23 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 20, 1885	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) SOUTH DAKOTA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK NAT'L. DEFENSE D. A. R.				10b. KIND OF BUSINESS OR INDUSTRY SOUTH DAKOTA			
13. FATHER'S NAME CYRUS RAYNSFORD				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-16-6800		17. INFORMANT THOMAS B. PENICKS, 2109 HANOVER ST., SILVER SPRING			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Liver DUE TO (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2 days 7 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/24/58 , 19 58 , to 8/23 , 19 58 , that I last saw the deceased alive on 8/23 , 19 58 , and that death occurred at 10:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9321 GEORGIA AVE., SILVER SPRING DATE SIGNED 8/24/58 ACTUAL SIGNATURE Naomi T. Lucius PHYSICIAN'S NAME (Type) NAOMI T. LUCIUS							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF AUG. 24, 1958		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR AUG 26 '58 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1500

1500

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>10-15-1880</u></p>	
<p>5. Place of birth: <u>NEW YORK</u></p>		<p>6. Date of death: <u>11-10-1925</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Signature of registrar: <u>John J. Smith</u></p>	
<p>11. Signature of informant: <u>John J. Smith</u></p>		<p>12. Signature of witness: <u>John J. Smith</u></p>	
<p>13. Signature of undertaker: <u>John J. Smith</u></p>		<p>14. Signature of funeral home: <u>John J. Smith</u></p>	
<p>15. Signature of cemetery: <u>John J. Smith</u></p>		<p>16. Signature of burial place: <u>John J. Smith</u></p>	
<p>17. Signature of interment: <u>John J. Smith</u></p>		<p>18. Signature of final disposition: <u>John J. Smith</u></p>	
<p>19. Signature of final disposition: <u>John J. Smith</u></p>		<p>20. Signature of final disposition: <u>John J. Smith</u></p>	
<p>21. Signature of final disposition: <u>John J. Smith</u></p>		<p>22. Signature of final disposition: <u>John J. Smith</u></p>	
<p>23. Signature of final disposition: <u>John J. Smith</u></p>		<p>24. Signature of final disposition: <u>John J. Smith</u></p>	
<p>25. Signature of final disposition: <u>John J. Smith</u></p>		<p>26. Signature of final disposition: <u>John J. Smith</u></p>	
<p>27. Signature of final disposition: <u>John J. Smith</u></p>		<p>28. Signature of final disposition: <u>John J. Smith</u></p>	
<p>29. Signature of final disposition: <u>John J. Smith</u></p>		<p>30. Signature of final disposition: <u>John J. Smith</u></p>	
<p>31. Signature of final disposition: <u>John J. Smith</u></p>		<p>32. Signature of final disposition: <u>John J. Smith</u></p>	
<p>33. Signature of final disposition: <u>John J. Smith</u></p>		<p>34. Signature of final disposition: <u>John J. Smith</u></p>	
<p>35. Signature of final disposition: <u>John J. Smith</u></p>		<p>36. Signature of final disposition: <u>John J. Smith</u></p>	
<p>37. Signature of final disposition: <u>John J. Smith</u></p>		<p>38. Signature of final disposition: <u>John J. Smith</u></p>	
<p>39. Signature of final disposition: <u>John J. Smith</u></p>		<p>40. Signature of final disposition: <u>John J. Smith</u></p>	
<p>41. Signature of final disposition: <u>John J. Smith</u></p>		<p>42. Signature of final disposition: <u>John J. Smith</u></p>	
<p>43. Signature of final disposition: <u>John J. Smith</u></p>		<p>44. Signature of final disposition: <u>John J. Smith</u></p>	
<p>45. Signature of final disposition: <u>John J. Smith</u></p>		<p>46. Signature of final disposition: <u>John J. Smith</u></p>	
<p>47. Signature of final disposition: <u>John J. Smith</u></p>		<p>48. Signature of final disposition: <u>John J. Smith</u></p>	
<p>49. Signature of final disposition: <u>John J. Smith</u></p>		<p>50. Signature of final disposition: <u>John J. Smith</u></p>	
<p>51. Signature of final disposition: <u>John J. Smith</u></p>		<p>52. Signature of final disposition: <u>John J. Smith</u></p>	
<p>53. Signature of final disposition: <u>John J. Smith</u></p>		<p>54. Signature of final disposition: <u>John J. Smith</u></p>	
<p>55. Signature of final disposition: <u>John J. Smith</u></p>		<p>56. Signature of final disposition: <u>John J. Smith</u></p>	
<p>57. Signature of final disposition: <u>John J. Smith</u></p>		<p>58. Signature of final disposition: <u>John J. Smith</u></p>	
<p>59. Signature of final disposition: <u>John J. Smith</u></p>		<p>60. Signature of final disposition: <u>John J. Smith</u></p>	
<p>61. Signature of final disposition: <u>John J. Smith</u></p>		<p>62. Signature of final disposition: <u>John J. Smith</u></p>	
<p>63. Signature of final disposition: <u>John J. Smith</u></p>		<p>64. Signature of final disposition: <u>John J. Smith</u></p>	
<p>65. Signature of final disposition: <u>John J. Smith</u></p>		<p>66. Signature of final disposition: <u>John J. Smith</u></p>	
<p>67. Signature of final disposition: <u>John J. Smith</u></p>		<p>68. Signature of final disposition: <u>John J. Smith</u></p>	
<p>69. Signature of final disposition: <u>John J. Smith</u></p>		<p>70. Signature of final disposition: <u>John J. Smith</u></p>	
<p>71. Signature of final disposition: <u>John J. Smith</u></p>		<p>72. Signature of final disposition: <u>John J. Smith</u></p>	
<p>73. Signature of final disposition: <u>John J. Smith</u></p>		<p>74. Signature of final disposition: <u>John J. Smith</u></p>	
<p>75. Signature of final disposition: <u>John J. Smith</u></p>		<p>76. Signature of final disposition: <u>John J. Smith</u></p>	
<p>77. Signature of final disposition: <u>John J. Smith</u></p>		<p>78. Signature of final disposition: <u>John J. Smith</u></p>	
<p>79. Signature of final disposition: <u>John J. Smith</u></p>		<p>80. Signature of final disposition: <u>John J. Smith</u></p>	
<p>81. Signature of final disposition: <u>John J. Smith</u></p>		<p>82. Signature of final disposition: <u>John J. Smith</u></p>	
<p>83. Signature of final disposition: <u>John J. Smith</u></p>		<p>84. Signature of final disposition: <u>John J. Smith</u></p>	
<p>85. Signature of final disposition: <u>John J. Smith</u></p>		<p>86. Signature of final disposition: <u>John J. Smith</u></p>	
<p>87. Signature of final disposition: <u>John J. Smith</u></p>		<p>88. Signature of final disposition: <u>John J. Smith</u></p>	
<p>89. Signature of final disposition: <u>John J. Smith</u></p>		<p>90. Signature of final disposition: <u>John J. Smith</u></p>	
<p>91. Signature of final disposition: <u>John J. Smith</u></p>		<p>92. Signature of final disposition: <u>John J. Smith</u></p>	
<p>93. Signature of final disposition: <u>John J. Smith</u></p>		<p>94. Signature of final disposition: <u>John J. Smith</u></p>	
<p>95. Signature of final disposition: <u>John J. Smith</u></p>		<p>96. Signature of final disposition: <u>John J. Smith</u></p>	
<p>97. Signature of final disposition: <u>John J. Smith</u></p>		<p>98. Signature of final disposition: <u>John J. Smith</u></p>	
<p>99. Signature of final disposition: <u>John J. Smith</u></p>		<p>100. Signature of final disposition: <u>John J. Smith</u></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

M

00

I

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09294

9304

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE FLORIDA b. COUNTY BROWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN lb 2 MONTHS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLYWOOD 48 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 731 SILVER SPRING AVENUE		d. STREET ADDRESS 1829 FUNSTON STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) NELLIE CAROLINE PERSON		4. DATE OF DEATH Month AUGUST Day 17 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ANGEL ISLAND, CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FREDERICK LUTZE		14. MOTHER'S MAIDEN NAME ELLEN P. EDGERTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JOHN T. McMENOMY, 731 SILVER SPRING AVE., S.S.,		Address MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis - DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 min. 20 yr.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		DATE SIGNED AUG. 17, 1958	
EXAMINER'S NAME (Type) JOHN G. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF AUG. 20, 1958	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY, FORT MYER, VA.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR DATE AUG 22 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur L. House	

9305

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own home				d. STREET ADDRESS 4405 Everett St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MYRTIE Middle E. Last PETERSEN				4. DATE OF DEATH Month Aug. Day 20 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1873		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canton Pa.	
13. FATHER'S NAME Rufus B. Denmark				14. MOTHER'S MAIDEN NAME Emily A. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Peter W. Petersen 4405 Everett St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Acute coronary thrombosis DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic heart failure (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 4 hour years 2 years 10 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1946 , 19 Aug 16 , 19 58 , that I last saw the deceased alive on Aug 16 , 19 58 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C.P. Ryland				ADDRESS (Street, city or town, state) 4400-49 St NW. Washington 16. DC			
PHYSICIAN'S NAME (Type) C.P. RYLAND				DATE SIGNED 8-20-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 23, 1958		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral Home 300 4th St. N.E.				24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Jan 15 1900		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Disease		9. PRESENT ILLNESS Angina Pectoris	
10. OCCASION OF DEATH Sudden		11. PLACE OF BIRTH Maryland		12. DATE OF BIRTH Jan 15 1855	
13. NAME OF MOTHER Mary Ann Brown		14. NAME OF FATHER John Brown		15. NAME OF SPOUSE Mary Ann Brown	
16. NAME OF REGISTRAR J. H. Brown		17. SIGNATURE OF REGISTRAR J. H. Brown		18. SIGNATURE OF DECEASED J. H. Brown	
19. SIGNATURE OF WITNESSES J. H. Brown		20. SIGNATURE OF DECEASED J. H. Brown		21. SIGNATURE OF DECEASED J. H. Brown	
22. SIGNATURE OF DECEASED J. H. Brown		23. SIGNATURE OF DECEASED J. H. Brown		24. SIGNATURE OF DECEASED J. H. Brown	
25. SIGNATURE OF DECEASED J. H. Brown		26. SIGNATURE OF DECEASED J. H. Brown		27. SIGNATURE OF DECEASED J. H. Brown	
28. SIGNATURE OF DECEASED J. H. Brown		29. SIGNATURE OF DECEASED J. H. Brown		30. SIGNATURE OF DECEASED J. H. Brown	
31. SIGNATURE OF DECEASED J. H. Brown		32. SIGNATURE OF DECEASED J. H. Brown		33. SIGNATURE OF DECEASED J. H. Brown	
34. SIGNATURE OF DECEASED J. H. Brown		35. SIGNATURE OF DECEASED J. H. Brown		36. SIGNATURE OF DECEASED J. H. Brown	
37. SIGNATURE OF DECEASED J. H. Brown		38. SIGNATURE OF DECEASED J. H. Brown		39. SIGNATURE OF DECEASED J. H. Brown	
40. SIGNATURE OF DECEASED J. H. Brown		41. SIGNATURE OF DECEASED J. H. Brown		42. SIGNATURE OF DECEASED J. H. Brown	
43. SIGNATURE OF DECEASED J. H. Brown		44. SIGNATURE OF DECEASED J. H. Brown		45. SIGNATURE OF DECEASED J. H. Brown	
46. SIGNATURE OF DECEASED J. H. Brown		47. SIGNATURE OF DECEASED J. H. Brown		48. SIGNATURE OF DECEASED J. H. Brown	
49. SIGNATURE OF DECEASED J. H. Brown		50. SIGNATURE OF DECEASED J. H. Brown		51. SIGNATURE OF DECEASED J. H. Brown	
52. SIGNATURE OF DECEASED J. H. Brown		53. SIGNATURE OF DECEASED J. H. Brown		54. SIGNATURE OF DECEASED J. H. Brown	
55. SIGNATURE OF DECEASED J. H. Brown		56. SIGNATURE OF DECEASED J. H. Brown		57. SIGNATURE OF DECEASED J. H. Brown	
58. SIGNATURE OF DECEASED J. H. Brown		59. SIGNATURE OF DECEASED J. H. Brown		60. SIGNATURE OF DECEASED J. H. Brown	
61. SIGNATURE OF DECEASED J. H. Brown		62. SIGNATURE OF DECEASED J. H. Brown		63. SIGNATURE OF DECEASED J. H. Brown	
64. SIGNATURE OF DECEASED J. H. Brown		65. SIGNATURE OF DECEASED J. H. Brown		66. SIGNATURE OF DECEASED J. H. Brown	
67. SIGNATURE OF DECEASED J. H. Brown		68. SIGNATURE OF DECEASED J. H. Brown		69. SIGNATURE OF DECEASED J. H. Brown	
70. SIGNATURE OF DECEASED J. H. Brown		71. SIGNATURE OF DECEASED J. H. Brown		72. SIGNATURE OF DECEASED J. H. Brown	
73. SIGNATURE OF DECEASED J. H. Brown		74. SIGNATURE OF DECEASED J. H. Brown		75. SIGNATURE OF DECEASED J. H. Brown	
76. SIGNATURE OF DECEASED J. H. Brown		77. SIGNATURE OF DECEASED J. H. Brown		78. SIGNATURE OF DECEASED J. H. Brown	
79. SIGNATURE OF DECEASED J. H. Brown		80. SIGNATURE OF DECEASED J. H. Brown		81. SIGNATURE OF DECEASED J. H. Brown	
82. SIGNATURE OF DECEASED J. H. Brown		83. SIGNATURE OF DECEASED J. H. Brown		84. SIGNATURE OF DECEASED J. H. Brown	
85. SIGNATURE OF DECEASED J. H. Brown		86. SIGNATURE OF DECEASED J. H. Brown		87. SIGNATURE OF DECEASED J. H. Brown	
88. SIGNATURE OF DECEASED J. H. Brown		89. SIGNATURE OF DECEASED J. H. Brown		90. SIGNATURE OF DECEASED J. H. Brown	
91. SIGNATURE OF DECEASED J. H. Brown		92. SIGNATURE OF DECEASED J. H. Brown		93. SIGNATURE OF DECEASED J. H. Brown	
94. SIGNATURE OF DECEASED J. H. Brown		95. SIGNATURE OF DECEASED J. H. Brown		96. SIGNATURE OF DECEASED J. H. Brown	
97. SIGNATURE OF DECEASED J. H. Brown		98. SIGNATURE OF DECEASED J. H. Brown		99. SIGNATURE OF DECEASED J. H. Brown	
100. SIGNATURE OF DECEASED J. H. Brown		101. SIGNATURE OF DECEASED J. H. Brown		102. SIGNATURE OF DECEASED J. H. Brown	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9306 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09296

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1604 Henry Road</u>	
3. NAME OF DECEASED (Type or print) <u>Marsha Lynn Phillips</u>		4. DATE OF DEATH <u>August 13 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1951</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR <u>7</u> Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Stanley Thomas Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Ricketts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address <u>Dorothy R. Phillips</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>849X</u> DUE TO (b) <u>Cerebral lacerations and subdural hematoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Fracture, left parietal and occipital bones</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 3/4 hrs.</u> <u>3 3/4 hrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Feed while riding bicycle</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>6:15 a.m. 8-13 1958</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sidewalk</u>		20f. (City or town) (County) (State) <u>Rockville monty md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>AUG 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICIAL RECORD

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: Robert A. Thompson
AGE: 45
SEX: Male
RACE: White
DATE OF DEATH: 10/15/1915
PLACE OF DEATH: Home
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: Robert A. Thompson
OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MARYLAND

9307 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>35 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1907 Langerme Ave</u>				d. STREET ADDRESS <u>1907 Langerme Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jesse Garfield Pratt</u> First Middle Last				4. DATE OF DEATH <u>Aug 27 1958</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-24-81</u>	
				9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. Pratt</u>				14. MOTHER'S MAIDEN NAME <u>Fannie B. Hazard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-24-2622</u>		17. INFORMANT <u>Reeve Pratt (son)</u> Address <u>12211 Indian Rd Silver Spring, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> <u>976X</u> DUE TO (b) <u>bullet wound thru skull</u> Conditions, if any, which gave rise to immediate cause (c) <u>bullet wound thru skull</u> (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Disorder due to cornu of lung</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound thru skull</u>					
20c. TIME OF INJURY Month, Day, Year <u>12:01 p.m. 8-27 1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Silver Spring Montg md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) <u>PRINCE GEORGE'S COUNTY, MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harner E. Pumphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REGD BY REGISTRAR <u>AUG 29 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Franz</u>	

FOR STATE
MEDICAL DEPT.

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN WHO HAS EXAMINED THE DECEASED, AND IS TO BE SUBMITTED TO THE STATE MEDICAL DEPARTMENT, ALONG WITH THE BODY, FOR THE PURPOSE OF DETERMINING THE CAUSE OF DEATH, AND THE MANNER IN WHICH IT OCCURRED. IT IS TO BE FURNISHED TO THE STATE MEDICAL DEPARTMENT, ALONG WITH THE BODY, FOR THE PURPOSE OF DETERMINING THE CAUSE OF DEATH, AND THE MANNER IN WHICH IT OCCURRED.

THE PHYSICIAN WHO HAS EXAMINED THE DECEASED, AND IS TO BE SUBMITTED TO THE STATE MEDICAL DEPARTMENT, ALONG WITH THE BODY, FOR THE PURPOSE OF DETERMINING THE CAUSE OF DEATH, AND THE MANNER IN WHICH IT OCCURRED.

STATE OF MARYLAND

1. Name of Deceased: John Doe
2. Age: 45
3. Sex: Male
4. Date of Death: 10/15/1918
5. Place of Death: Home
6. Cause of Death: Heart Disease
7. Manner of Death: Natural
8. Signature of Physician: John Doe
9. Signature of Medical Examiner: John Doe
10. Signature of Coroner: John Doe

MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD.
9307 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9191

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>8608 2nd Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Griffith</u> XXXXXX <u>Preston</u>				4. DATE OF DEATH Month <u>8</u> - Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-26-68</u> yrs.	
9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Homemaker Own home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>America</u>	
13. FATHER'S NAME <u>Samuel Ball Fisher MD.</u>				14. MOTHER'S MAIDEN NAME <u>Anella Bohe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss Phoebe Preston - Daughter</u> Address <u>Same address.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Boeschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Boeschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Aug 4 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Aug 6 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1101

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09299

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium		d. STREET ADDRESS 10231 Carroll Place	
3. NAME OF DECEASED (Type or print) RICHARD First Middle Last POCHER		4. DATE OF DEATH AUG 15 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH -- 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Surgeon		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mabel Benson Sakis		Address Wash. Loan & Tr. Bldg Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 11, 1958 to AUG. 15, 1958 , that I last saw the deceased alive on AUG. 15, 1958 , and that death occurred at 3:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Lowden M.D.		ADDRESS (Street, city or town, state) 5206 NORWAY DR. CHERRY CHASE, Md	
PHYSICIAN'S NAME (Type) Henry M. LOWDEN		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/19/1958	22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	22d. LOCATION (City, town, or county) (State) Alexandria, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co 2901-14th St N.W. Wash D.C.		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

100

9309

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	c. LENGTH OF STAY IN 1b <u>47 YEARS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9107 SECOND AVENUE</u>		d. STREET ADDRESS <u>19107 SECOND AVENUE</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>M.</u> Last <u>RAGSDALE</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Lock Haven, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOHN N. GAST</u>	
14. MOTHER'S MAIDEN NAME <u>HARRIET S. MEYERS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>577-03-4467</u>		17. INFORMANT <u>WILSON RAGSDALE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MITRAL INSUFFICIENCY</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MOS.</u> <u>3 YEARS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) (State)	
21. I certify that I attended the deceased from <u>OCT. 10, 1957</u> , to <u>AUGUST 18, 1958</u> , that I last saw the deceased alive on <u>AUGUST 18, 1958</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>8907 GEORGIA AVE SILVER SPRING, MD</u>		DATE SIGNED <u>AUG. 18, 1958</u>	
ACTUAL SIGNATURE <u>James A. Roberts</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		<u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 22, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lock Haven, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner G. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Jakoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7803 Lockney Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>F.</u> Last <u>READ</u>				4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 19, 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Man</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Read</u>				14. MOTHER'S MAIDEN NAME <u>Not Available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Huldah P. Read</u> Address <u>(Same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CORONARY ARTERY DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-4 HRS</u> <u>24 HRS.</u> <u>1 YR +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. p.</u> Month <u>19</u> Day <u>19</u> Year <u>1958</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/11</u> , 19 <u>58</u> , to <u>8/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/6</u> , 19 <u>58</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Sterling</u>				ADDRESS (Street, city or town, state) <u>1352 UNIVERSITY ROAD HYATTSVILLE, MD.</u>			
DATE SIGNED <u>8/18/58</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>				M.D. <u>HYATTSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 20, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll Street D.C.</u>				24. REC'D BY REGISTRAR <u>AUG 20 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

9193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) LAKOMA PARK c. LENGTH OF STAY IN 1b 16.15.2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE d. STREET ADDRESS 3103 NICHOLSON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET JANE REEVES		4. DATE OF DEATH Month Day Year AUGUST 16 1958	
5. SEX FE	6. COLOR OR RACE WH	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-05
9. AGE (In years lost birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF.	11. BIRTHPLACE (State or foreign country) SCOTLAND
12. CITIZEN OF WHAT COUNTRY? CANADA		13. FATHER'S NAME JOHN MURDOCH	
14. MOTHER'S MAIDEN NAME MARGARET COCHRANE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adverse in septicemia 541.0 DUE TO Post-operative Subtotal Prostatectomy Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) Obstructing Duodenal ulcer		INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 12, 1958 , to August 16, 1958 , that I last saw the deceased alive on August 16, 1958 , and that death occurred at 4:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lyle Williams		ADDRESS (Street, city or town, state) 8700 Calverville Rd. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Lyle Williams M.D.		DATE SIGNED Aug 16, 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 18, 1958	22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery	22d. LOCATION (City, town, or county) (State) Prince Geo. Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		ADDRESS 254 Carroll Ave. N.W. D.C.	
24a. REC'D BY REGISTRAR DATE AUG 19 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

NO. 1011

PLACE OF DEATH

RESIDENCE

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

NAME OF BURIAL PLACE

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF FUNERAL HOME

NAME OF UNDERTAKER

NAME OF DRIVER

NAME OF ASSISTANT

NAME OF BELLMAN

NAME OF MUSICIAN

NAME OF FLORIST

NAME OF COFFIN

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09303

9202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1622 Burris Rd.		d. STREET ADDRESS 1622 Burris Rd.	
3. NAME OF DECEASED (Type or print) First ERNEST Middle B. RENNINGER Last		4. DATE OF DEATH Month Aug. Day 3, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1916
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10b. KIND OF BUSINESS OR INDUSTRY Gov't	
11. BIRTHPLACE (State or foreign country) Boyertown, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ernest B. Renninger		14. MOTHER'S MAIDEN NAME Florence Bird	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 185-05-1550	
17. INFORMANT Wife		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency (c) and Angina Pectoris		INTERVAL BETWEEN ONSET AND DEATH 15 min 4 1/2 yrs 4 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February, 1957 , to 3 Aug., 1958 , that I last saw the deceased alive on 12 July, 1958 , and that death occurred at 2:00 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. Rockville, Md. DATE SIGNED 8-3-58 ACTUAL SIGNATURE W. G. Hall M.D. 615 W. Montgomery Ave. Rockville, Md. PHYSICIAN'S NAME (Type) W. G. Hall			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE AUG 5 '58		24b. REGISTRAR'S SIGNATURE W. G. Hall	

9194

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>			d. STREET ADDRESS <u>6818 Spencer Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Henry</u> Last <u>Rice</u>			4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-99</u>	9. AGE (In years lost birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney at law - Dept. of Defense</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. States</u>			13. FATHER'S NAME <u>Henry J. Rice</u>		
14. MOTHER'S MAIDEN NAME <u>Annie Atwell</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.II</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <u>Chevy Chase, Md.</u> <u>Mrs. Vera C. Rice - 2818 Spencer Rd.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Gastric Intoxication</u>					<u>12 hrs</u>
610X DUE TO <u>Supra pubic prostatic</u>					<u>3 1/2 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u>					<u>10-15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-3-58</u> , 19 <u>58</u> , to <u>8-14-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-14-58</u> , 19 <u>58</u> , and that death occurred at <u>11:18</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Oliver E. Thompson</u> M.D.			ADDRESS (Street, city or town, state) <u>1835 Eye St. N.W.</u> DATE SIGNED <u>Wash. D.C.</u>		
PHYSICIAN'S NAME (Type) <u>Oliver E. Thompson</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company-Washington, DC</u>			24a. REC'D BY REGISTRAR <u>DATE AUG 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9310

CERTIFICATE OF DEATH

10395

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 1638.2	
c. LENGTH OF STAY IN 1b 3 days		d. STREET ADDRESS 2418 Lake Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pearl Middle Proffit Last RIDLEY		4. DATE OF DEATH Month August Day 24 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 March 1887
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Prince Edward Isa. Canada		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James H. Proffit		14. MOTHER'S MAIDEN NAME Charlotte Crozier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 12-26-5735	
17. INFORMANT (Daughter) Mrs. Charlotte R. Walkins (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular occlusion 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 August , 19 58 , to 24 August , 19 58 , that I last saw the deceased alive on 24 August , 19 58 , and that death occurred at 12:30P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James M. Young, M.D.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-25-58	
PHYSICIAN'S NAME (Type) James M. Young, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-29-58	
22c. NAME OF CEMETERY OR CREMATORY Forrestdale Cemetery		22d. LOCATION (City, town, or county) (State) Holyoke, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch & Sons, Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE AUG 26 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon copy of the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9311

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G-233 8-18-58 et

CERTIFICATE OF DEATH

Items 8 & 9, Film G-233 9/11/58, cac

Reg. Dist. No.

09305

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 1636.2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights d. STREET ADDRESS 208 61st Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY W. ROBBINS		4. DATE OF DEATH Month August Day 11 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOV 2, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ENGLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES WILKINSON		14. MOTHER'S MAIDEN NAME MARY A. BIDDLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MABEL A. PHINNEY STEP DAUGHTER		17. ADDRESS 4333 N. 2ND AVE PHOENIX, ARIZONA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cor. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Cor. Disease DUE TO (c) Thrombosed atherosclerotic		INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1956 to Aug 11, 1958 , that I last saw the deceased alive on Aug 11, 1958 , and that death occurred at 8:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1719 Louisiana St S.W. 8-1158 DATE SIGNED Arthur S. Frank ACTUAL SIGNATURE Arthur S. Frank M.D. PHYSICIAN'S NAME (Type) Arthur S. Frank			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-15-58	
22c. NAME OF CEMETERY OR CREMATORY GLENNWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc.		24a. REC'D BY REGISTRAR DATE AUG 13 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

CERTIFICATE OF DEATH

Bill

BOILED

18



9312

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>13 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>15720 - Hunting Park</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Ezra Ross</u>		4. DATE OF DEATH Month Day Year <u>Aug 2 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3/1894</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>0 29</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor of Sales</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Rubber Co. Mass.</u>	
11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Ross</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes-unknown</u>	
17. INFORMANT <u>Mrs. Lillian Ross</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION ACUTE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC HEART DIS.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA COLON RECURRENT</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/1</u> , 19 <u>58</u> , to <u>8/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/2</u> , 19 <u>58</u> , and that death occurred at <u>10:28 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Charles J. Savarese, M.D. 4806 East Bayle Rd. Bethesda, Md.</u>			
ACTUAL SIGNATURE <u>Charles J. Savarese, M.D.</u>		PHYSICIAN'S NAME (Type) <u>CHANCE J. SAVARESE, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-6-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and filed with the burial-transit permit. Then please remove carbon copy of the certificate and file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9313

CERTIFICATE OF DEATH

09307

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN TB 20 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS 8803 2nd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle C Last SABIN		4. DATE OF DEATH Month AUGUST Day 6 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/74	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer & Painter		10b. KIND OF BUSINESS OR INDUSTRY Wash. Gas Light Co.		11. BIRTHPLACE (State or foreign country) Nebraska	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Corwin Sabin			
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 577-07-9148		17. INFORMANT Mrs. F. L. Goodwin, 8803 2nd Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse, low blood pressure 300.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) Dementia Praecox		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 weeks 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan., 1948 to Aug 6, 1958 , that I last saw the deceased alive on Aug. 5, 1958 , and that death occurred at about 2 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank G. Leslie		ADDRESS (Street, city or town, state) 8901 Ba Av Silver Spring Md DATE SIGNED Aug 6, 58			
PHYSICIAN'S NAME (Type) FRANK G. LESLIE					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/8/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	
22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.		23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey ADDRESS SILVER SPRING, MD.			
24a. REC'D BY REGISTRAR DATE AUG 8 '58		24b. REGISTRAR'S SIGNATURE W. E. Humphrey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from this certificate and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

FILE NO.

DATE OF DEATH

PLACE

AGE

CAUSE OF DEATH

SEX

EDUCATION

DATE OF BIRTH

RELIGION

PROFESSION

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE

AGE

CAUSE OF DEATH

SEX

EDUCATION

DATE OF BIRTH

RELIGION

PROFESSION

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE

AGE

CAUSE OF DEATH

SEX

EDUCATION

DATE OF BIRTH

RELIGION

PROFESSION

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE

AGE

CAUSE OF DEATH

SEX

EDUCATION

DATE OF BIRTH

RELIGION

PROFESSION

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE

AGE

CAUSE OF DEATH

SEX

EDUCATION

DATE OF BIRTH

RELIGION

PROFESSION

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE

AGE

CAUSE OF DEATH

SEX

EDUCATION

DATE OF BIRTH

RELIGION

PROFESSION

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE

AGE

CAUSE OF DEATH

SEX

EDUCATION

DATE OF BIRTH

RELIGION

PROFESSION

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE

AGE

CAUSE OF DEATH

SEX

EDUCATION

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda, Md.				d. STREET ADDRESS Circle Drive, Glenn Hills			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last John Leonard SCHAEFER				4. DATE OF DEATH Month Day Year August 17 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 May 1871	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special police Officer				10b. KIND OF BUSINESS OR INDUSTRY Bellman Brook Paper Company		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Leonard SCHAEFER				14. MOTHER'S MAIDEN NAME Christine (Last name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT (Daughter) Aneete HALL		Address (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Generalized DUE TO (c) Cerebral Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 1230 P				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from 13 August, 1958 , to 17 August, 1958 , that I last saw the deceased alive on 17 August, 1958 , and that death occurred at 1230 P , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 8-17-58 ACTUAL SIGNATURE August Miale Jr PHYSICIAN'S NAME (Type) A. MIALE JR. LT MC USN U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-58		22c. NAME OF CEMETERY OR CREMATORY George Washington Memorial		22d. LOCATION (City, town, or county) (State) Park Paramus New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. HINES, 2901 14th Street N.W. Washington D.C.				24a. REC'D BY REGISTRAR DATE AUG 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be buried with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		MANNER OF DEATH	
CAUSE OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
PREVIOUS ILLNESS		TREATMENT	
SIGNS AND SYMPTOMS		LABORATORY TESTS	
POST-MORTEM EXAMINATION		HISTORICAL DATA	
FAMILY HISTORY		SOCIAL HISTORY	
SMOKING HISTORY		ALCOHOLIC HISTORY	
DRUG HISTORY		DIETARY HISTORY	
EXERCISE HISTORY		STRESS HISTORY	
ENVIRONMENTAL FACTORS		GENETIC FACTORS	
MEDICAL HISTORY		SURGICAL HISTORY	
VACCINATION HISTORY		TRANSFUSION HISTORY	
ALLERGIC HISTORY		IMMUNIZATION HISTORY	
CHRONIC DISEASES		ACUTE DISEASES	
TRAUMA HISTORY		INFECTIOUS DISEASES	
NEOPLASIA HISTORY		ENDOCRINE DISEASES	
RESPIRATORY DISEASES		CARDIOVASCULAR DISEASES	
GASTROINTESTINAL DISEASES		UROLOGICAL DISEASES	
REPRODUCTIVE DISEASES		MUSCULOSKELETAL DISEASES	
NEUROLOGICAL DISEASES		PSYCHIATRIC DISEASES	
HEMATOLOGICAL DISEASES		IMMUNOLOGICAL DISEASES	
METABOLIC DISEASES		TOXICOLOGICAL DISEASES	
OTHER DISEASES		UNIDENTIFIED DISEASES	

STATE OF MARYLAND



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26			
				d. STREET ADDRESS 712 Woodburn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Schanberger Last Schanberger				4. DATE OF DEATH Month August Day 19 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1878	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 1 Days 2 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Reading, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Schanberger				14. MOTHER'S MAIDEN NAME Matilda, K n Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-42-9058		17. INFORMANT Son Address 3811 Ridgeway Ave. Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of Prostate INTERVAL BETWEEN ONSET AND DEATH 2 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 July, 1958 to 18 August, 1958 , that I last saw the deceased alive on 18 August, 1958 , and that death occurred at 4:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 909 Pershing Drive DATE SIGNED 8/19/58							
ACTUAL SIGNATURE Arthur J. Wilets M.D. 909 Pershing Drive 8/19/58							
PHYSICIAN'S NAME (Type) Arthur J. Wilets Silver Spring, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Switzland Prince Geo. County Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE AUG 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9316

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09310

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6812 Delaware Street</u>				d. STREET ADDRESS <u>6812 Delaware Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>C</u> Last <u>SCHERR</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1884</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stott Pub. Co-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Julius Sherr</u>				14. MOTHER'S MAIDEN NAME <u>Emale Sievers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>298-07-4977</u>		17. INFORMANT <u>Henry L Sherr, brother, same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John G. Ball</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>8/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East Oak Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Morgantown, W. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 19 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9195

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09311

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 17		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7620 Maple Ave. Apt. 436			d. STREET ADDRESS 7620 Maple Ave Apt. 436		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) James Emmett Shea			4. DATE OF DEATH Month Aug. Day 8, Year 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1896.		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blg. Contr. (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Gen. Bldg. Trades		11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Bernard Shea			14. MOTHER'S MAIDEN NAME Mary Ann Welch		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Eva F. Shea Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		8/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/11/58	22c. NAME OF CEMETERY OR CREMATORY Beahm's Chapel Cem.		22d. LOCATION (City, town, or county) (State) Luray, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.		24b. REGISTRAR'S SIGNATURE Alfred	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9317

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY 85x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 88 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wiley Middle Edward Last Shrewsbury		4. DATE OF DEATH Month August Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 60 Hours 60 Min. 60	IF UNDER 24 HRS. Months 60 Days 60 Hours 60 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry W. Shrewsbury		14. MOTHER'S MAIDEN NAME Annie Munsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.0 Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Silicosis & pulmonary reticulum cell sarcoma 1 yr. DUE TO (c) Reticulum cell sarcoma 1 yr.		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1958 , to August 8, 1958 , that I last saw the deceased alive on August 8, 1958 , and that death occurred at 9:43 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Nathan S. Taylor		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D.		DATE SIGNED 8-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 8-12-58	
22c. NAME OF CEMETERY OR CREMATORY Matoka		22d. LOCATION (City, town, or county) (State) Matoka, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Aug 12 1958	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Krueger	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9318

CERTIFICATE OF DEATH

09313

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				d. STREET ADDRESS <u>15 E. st. NW</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennie Carter Simon</u>				4. DATE OF DEATH Month Day Year <u>Aug 28 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 10, 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>William Carter</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Giffin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Jennie Carter Simon</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolisation</u> <u>466 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Phlebothrombosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/21</u> , 19 <u>58</u> , to <u>8/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>58</u> , and that death occurred at <u>7:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Prokopos Colevas</u>				DATE SIGNED <u>1120 16th St NW Washington DC 8/28/58</u>			
PHYSICIAN'S NAME (Type) <u>Prokopos Colevas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9319

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2728 RANDOLPH ROAD</u>		d. STREET ADDRESS <u>1 2728 RANDOLPH ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>De Witt Talmadge Smith</u>		4. DATE OF DEATH <u>8</u> Month <u>10</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/95</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - Gen. Accounting U.S. Gov't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NORTH CAROLINA</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM LINCOLN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>LULA BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW # 1 & 2</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Nina Pearl Smith, 2728 Randolph Road</u>		Address <u>Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>None</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/28/58</u> , 19 <u>58</u> , to <u>8/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>58</u> , and that death occurred at <u>107</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhau</u> M.D.		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u> DATE SIGNED <u>8/10/58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAN</u>		<u>Chesapeake 15 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Kravitz</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kravitz</u>	

AUG 12 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0.125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 3. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9320

CERTIFICATE OF DEATH

09315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
f. STREET ADDRESS <u>1 RFD #3</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fanny Gertrude Smith</u>				4. DATE OF DEATH Month Day Year <u>Aug 24 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1873</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Mereness</u>				14. MOTHER'S MAIDEN NAME <u>Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>William F Smith, 9332 Villa Dr. Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Intestinal Bleeding</u> <u>151X</u> DUE TO <u>CA gastric</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CA gastric</u> DUE TO (c) <u>CA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CA Recto Sigmoid & Bladder</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>Oct 1950</u> , to <u>24 Aug 1958</u> , that I last saw the deceased alive on <u>24 Aug 1958</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>615 W. Montgomery and Rockville Hwy</u> DATE SIGNED <u>25 Aug 1958</u>							
ACTUAL SIGNATURE <u>W.S. Murphy</u>		PHYSICIAN'S NAME (Type) <u>Wm. S. Murphy</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9321
CERTIFICATE OF DEATH

09316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 42 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY P.H. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16 X-2		d. STREET ADDRESS 6404 Buchanan Street, N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Raymond Middle William Last Snyder		4. DATE OF DEATH Month August Day 25, Year 19 58		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1906		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Offset Plate Maker		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Snyder		14. MOTHER'S MAIDEN NAME Ida Roberts		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.4 Abscess of Left Temporal lobe of brain DUE TO (b) Staphylococcal Septicemia DUE TO (c) Aplastic anemia		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks 1 year		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 292.4		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 14, 1958 to August 25, 1958 , that I last saw the deceased alive on August 25, 1958 , and that death occurred at 12:25 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE Peter S. Mueller, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 8/25/58		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-29-58		22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l.		22d. LOCATION (City, town, or county) (State) FT MYER, Va.					
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS 5735 15th St SE Washington, D.C.		24a. REC'D BY REGISTRAR DATE AUG 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus													

CERTIFICATE OF DEATH

8821

Name of Deceased		Date of Death	
John Doe		May 20, 1950	
Sex		Age	
Male		45	
Race		Occupation	
White		Teacher	
Marital Status		Cause of Death	
Married		Heart Disease	
Place of Birth		Place of Death	
Baltimore, Md.		Baltimore, Md.	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Date of Registration	
May 25, 1950		May 25, 1950	

Vertical text on the right margin, likely a filing or processing stamp.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9322 CERTIFICATE OF DEATH

09317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>15 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Germantown</u> d. STREET ADDRESS <u>c/o Henry King</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Bernard</u> Last <u>Stewart</u>			4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>19 58</u>														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6/4/77</u>		9. AGE (In years lost birthday) <u>81</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Charles Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Louise Gordon</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>		Address <u>Olney, Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Pyelonephritis</u> DUE TO (c) <u>Prostatic Hypertrophy with Obstructing Uropathy</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 weeks</u> <u>Unknown</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>8/6</u> , 19 <u>58</u> , to <u>8/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/20</u> , 19 <u>58</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.																	
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state)				DATE SIGNED <u>8/22/58</u>									
PHYSICIAN'S NAME (Type) <u>C. H. Ligon, M. D.</u>				<u>Sandy Spring, Maryland</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>Cloppers, Md.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

MEDICAL CERTIFICATION

4

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9323

CERTIFICATE OF DEATH

09318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAYHILL, SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAYHILL, SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15,310 Layhill Road		d. STREET ADDRESS 15,310 Layhill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VIOLA L STEWART		4. DATE OF DEATH AUGUST 9 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/96
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES H. JENKINS		14. MOTHER'S MAIDEN NAME ARABELLE LaFEVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. John R. Stewart, 15,310 Layhill Road		Address Layhill, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease DUE TO (c) 20 years.		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1938 , to Aug 2, 1958 , that I last saw the deceased alive on Aug 2, 1958 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Wardrop M.D.		ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) W.B. WARDROP		DATE SIGNED 8/9/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/12/58	
22c. NAME OF CEMETERY OR CREMATORY ST. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR AUG 12 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Krueger	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, please detach from page 3 should be detached from the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01/18

9324

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 138 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY Iron Mountain c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 59X-3 d. STREET ADDRESS 602 East C Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lois Wilhelmina Straub				4. DATE OF DEATH Month Day Year August 2, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 15, 1902	
9. AGE (In years lost birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Palin				14. MOTHER'S MAIDEN NAME Frankie Phinney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 1950 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Metastatic adrenal carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 min. 11 mos.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 17, 19 58 , to August 2, 19 58 , that I last saw the deceased alive on August 2, 19 58 , and that death occurred at 12:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Theodore L. Goodfriend M.D. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-2-58 NAME (Type) Theodore L. Goodfriend, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, or other disposal Burial		22b. DATE THEREOF 8/6/58		22c. NAME OF CEMETERY OR CREMATORY Cemetery Park		22d. LOCATION (City, town, or county) (State) Iron Mountain, Mich.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey 7557				ADDRESS Wisconsin Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR Aug 5 '58	
				24b. REGISTRAR'S SIGNATURE W. L. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

45419

9325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>204 Poplar Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sullivan Jane Stuart</u>				4. DATE OF DEATH Month Day Year <u>Aug. 19 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 4 - 1870</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benson Cornell</u>				14. MOTHER'S MAIDEN NAME <u>Susan Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u> 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>(moribund condition)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs?</u> <u>years</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-25</u> , 19 <u>58</u> , to <u>8-18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-8</u> , 19 <u>58</u> , and that death occurred at <u>3:42</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Spencer</u>				ADDRESS (Street, city or town, state) <u>Columbia Road, Berwyn, Md.</u>			
PHYSICIAN'S NAME (Type) <u>JOHN R. SPENCER</u>				DATE SIGNED <u>April 8-1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u>				ADDRESS <u>mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 22 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH _____		MARRIAGE _____	
DATE OF BIRTH _____		DATE OF DEATH _____	
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		RACE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF DEATH _____		MEDICAL HISTORY _____	
NAME OF DECEASED _____		NAME OF REPORTER _____	
ADDRESS _____		CITY _____	
STATE _____		COUNTY _____	
ZIP CODE _____		SIGNATURE OF REPORTER _____	
DATE _____		SIGNATURE OF DECEASED _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF CLERK _____		SIGNATURE OF JUDGE _____	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased or by the medical examiner or coroner. It should be filled out as soon as possible after death and should be filed in the office of the health officer of the county in which the death occurred. A copy of this certificate should be sent to the family of the deceased and to the funeral home.

9326

CERTIFICATE OF DEATH

09321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ...			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 5 mins.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 3905 Jocelyn Street, N.W.			
3. NAME OF DECEASED (Type or print) First Thomas Middle R. Last Taylor				4. DATE OF DEATH Month August Day 19 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/90	9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist (Retired)				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Jackson Taylor				14. MOTHER'S MAIDEN NAME Martha Nuttall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 579-05-9950		17. INFORMANT Mary O Taylor Address 3905 Jocelyn St., N.W. Wash. DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, severe DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary sclerosis, severe (c) Arteriosclerosis & hypertension						INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 months 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1951 to Aug 19, 1958 , that I last saw the deceased alive on Aug 19, 1958 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart Clapp				M.D. 3921 Ingomar St		DATE SIGNED 8-19-58	
PHYSICIAN'S NAME (Type) Stewart Clapp				Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. - Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Hines Co. 2901-14 St. NW				24a. REC'D BY REGISTRAR DATE AUG 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		DATE OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CITY [Illegible]	
COUNTY [Illegible]		STATE [Illegible]	
AGE [Illegible]		SEX [Illegible]	
MARRIAGE [Illegible]		OCCUPATION [Illegible]	
EDUCATION [Illegible]		RELIGION [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

18

18

18

18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9327

CERTIFICATE OF DEATH

Reg. Dist. No. 215

09322

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE South Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN IB 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First "A" Middle "J" Last THOMAS				4. DATE OF DEATH Month August Day 4 Year 19 58			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 August 1926		9. AGE (In years last birthday) yrs. 31	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Calvin THOMAS				14. MOTHER'S MAIDEN NAME Erie RRAVEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes, Currently		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.6 MULTIPLE PULMONARY THROMBOSES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SICKLE CELL CRISIS DUE TO (c) SICKLE CELL ANEMIA						INTERVAL BETWEEN ONSET AND DEATH 36 hours 36 hours Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 August , 19 58 , to 4 August , 19 58 , that I last saw the deceased alive on 4 August , 19 58 , and that death occurred at 5:43A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE F. S. Caldwell				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-5-58			
PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-58		22c. NAME OF CEMETERY OR CREMATORY Beaufort Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Beaufort, S. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St. N.W. Wash. D. C.				24a. REC'D BY REGISTRAR AUG 6 '58		24b. REGISTRAR'S SIGNATURE Alfred...	

CERTIFICATE OF DEATH

1927

Name of Deceased [Illegible]		Sex [Illegible]		Age [Illegible]	
Date of Birth [Illegible]		Place of Birth [Illegible]		Usual Residence [Illegible]	
Date of Death [Illegible]		Time of Death [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]		Physician's Signature [Illegible]	
Coroner's Signature [Illegible]		Registrar's Signature [Illegible]		Date of Filing [Illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9328

CERTIFICATE OF DEATH

09323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami Shores 48X-3			
d. NAME OF HOSPITAL, if not in hospital, give street address, OR INSTITUTION Resmor Sanitarium & Hospital				d. STREET ADDRESS 9325 N.W. 2nd Court			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Milton Charles Thompson				4. DATE OF DEATH Month August 8 Day 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/16/1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist				10b. KIND OF BUSINESS OR INDUSTRY Medicine			
13. FATHER'S NAME Marion Clay Thompson				14. MOTHER'S MAIDEN NAME Elizabeth Caufield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578-01-2503			
17. INFORMANT Eva E. Thompson				Address Miami Shores, Fla. 9325 N.W. 2nd Court			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCEARDIAL INFARCTIO ACUTE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GEN' C ARTERIO SCLEROSIS DUE TO (c) anemia Hgb 52% INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 10+ YEARS 14 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular Accident, left cerebral art occl							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/25 , 19 58 , to 8/1 , 19 58 , that I last saw the deceased alive on 8/1 , 19 58 , and that death occurred at 2:15 p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4890 Battery Lane DATE SIGNED 8/1/58							
ACTUAL SIGNATURE Charles J. Savarese, Jr. M.D.							
PHYSICIAN'S NAME (Type) Charles J. Savarese, Jr. Bethesda Montgomery Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 8/11/58							
22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery Washington, D. C.							
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D. C.							
24a. REC'D BY REGISTRAR DATE AUG 11 '58							
24b. REGISTRAR'S SIGNATURE Alfred Smith							

CERTIFICATE OF DEATH

3022

Form No. 10

PLACE OF DEATH HOSPITAL		DATE OF DEATH JANUARY 10, 1962	
DECEASED HARRISON		SEX MALE	
AGE 68		RACE WHITE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION RETIRED		RELIGION METHODIST	
BIRTH JANUARY 10, 1894		PLACE OF BIRTH BALTIMORE, MARYLAND	
FATHER JAMES H. HARRISON		MOTHER MARY E. HARRISON	
PREVIOUS ILLNESS HEART DISEASE		CAUSE OF DEATH CORONARY THROMBOSIS	
IMMEDIATE CAUSE HEART FAILURE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. HARRISON		SIGNATURE OF DEATH REGISTRAR J. H. HARRISON	
DATE OF SIGNATURE JANUARY 10, 1962		PLACE OF SIGNATURE BALTIMORE, MARYLAND	



9329

CERTIFICATE OF DEATH

09324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 308 Tapawingo Road, S. E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leafy Middle Brandon Last Tibbs		4. DATE OF DEATH Month August Day 20 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Stone		14. MOTHER'S MAIDEN NAME Cora Seay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 223-20-8097	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FECAL PERITONITIS 171x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) NUMEROUS ENTERO-ENTERIC & ENTERO-CUTANEOUS FISTULAS 3 WEEKS DUE TO (c) CARCINOMA OF CERVIX - STATUS 4 YRS POST PELVIC EXENTERATION 4 YRS INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BILATERAL HYDRONEPHROSIS & CHRONIC PYELONEPHRITIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13 , 19 58 , to August 20 , 19 58 , that I last saw the deceased alive on August 20 , 19 58 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack H. Bloch, M.D. M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/21/58	
PHYSICIAN'S NAME (Type) Jack H. Bloch, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-23-58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Freightland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE DM Eickelbarger		24a. REC'D BY REGISTRAR DATE AUG 25 '58	
ADDRESS Vienna Virginia		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9330

CERTIFICATE OF DEATH

09325

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 125 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy-Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 4803 Morgan Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Robert Middle Gibson Last TOBIN				4. DATE OF DEATH Month August Day 11 Year 1958				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 August 1894		
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner, Rear Admiral, U.S. Navy, Retired			10b. KIND OF BUSINESS OR INDUSTRY West Virginia		11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert E. TOBIN				14. MOTHER'S MAIDEN NAME Nellie FARRELL				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I & II		17. INFORMANT Wife, Mrs. Carolyn O. TOBIN (Same As #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1939 Shrublstone multiforme bilateral. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH in excess of 1 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8 April , 19 58 , to 11 August , 19 58 , that I last saw the deceased alive on 11 August , 19 58 , and that death occurred at 11:00 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE W. H. Druckemiller				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 8-12-58				
PHYSICIAN'S NAME (Type) W. H. DRUCKEMILLER, CAPT, MC, USN				U.S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR AUG 14 '58		
				24b. REGISTRAR'S SIGNATURE Arthur S. Kunk				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6232 8/7/58

CERTIFICATE OF DEATH

9331

09326

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3820 Southern Avenue, S. E.			
3. NAME OF DECEASED (Type or print) First Malcolm Middle Claire Last Weyant Tomlinson				4. DATE OF DEATH Month August Day 4 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 16, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 6 Days 18		IF UNDER 24 HRS. Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Genealogist				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph Deacon Tomlinson				14. MOTHER'S MAIDEN NAME Katharine Virginia Dare Weyant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578-34-6130		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) 204.3 INTERVAL BETWEEN ONSET AND DEATH 4 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 23, 19 58 to August 4, 19 58 , that I last saw the deceased alive on August 4, 19 58 , and that death occurred at 12:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur T. Teplitzky M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Arthur T. Teplitzky, M. D.				DATE SIGNED 8-4-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/5/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory Prince George Co. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR AUG 6 '58	
				24b. REGISTRAR'S SIGNATURE W. Deane			

[illegible]

450-451

9332

CERTIFICATE OF DEATH

Reg. Dist. No.

09327

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 4600 High Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lacey Middle Balch Last Tschiffely				4. DATE OF DEATH Month August Day 30 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 13, 1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 10 Days 5 Hours 30 Min.		IF UNDER 24 HRS. Months 10 Days 5 Hours 30 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government				10b. KIND OF BUSINESS OR INDUSTRY Treasury Dept.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George R. Rice				14. MOTHER'S MAIDEN NAME Elberta Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Daughter Mrs. Dorothy T. Moore	
				Address As above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0 DUE TO Fall from back fence & legs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embolus from heart lit. (c) 10⁵⁵ Antell 30							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall at home			
20c. TIME OF INJURY Hour 4 p. m. Month 8 Day 9 Year 19 58				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) (County) (State) Chevy Chase Montgomery Md.			
21. I certify that I attended the deceased from 29 Aug. 1958 , to 30 Aug. 1958 , that I last saw the deceased alive on 29 Aug. 1958 , and that death occurred at 11:50 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1726 E. 10th Ave Wash D.C. DATE SIGNED Arthur S. House							
ACTUAL SIGNATURE Milton C. Coburn				M.D. 1726 E. 10th Ave Wash D.C.			
PHYSICIAN'S NAME (Type) Milton C. Coburn							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF SEPT 3, 1958		22c. NAME OF CEMETERY OR CREMATORY LEES CREMATORIUM		22d. LOCATION (City, town, or county) (State) 300 H² ST NE WASH D C	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees Sons - Wash D.C.				24a. REC'D BY REGISTRAR DATE SEP 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9333

CERTIFICATE OF DEATH

Reg. Dist. No.

09328

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 110 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1737 "P" Street, N.W.	
3. NAME OF DECEASED (Type or print) First Samuel Middle (nmn) Last VANCE		4. DATE OF DEATH Month August Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 15 March 1916
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank VANCE		14. MOTHER'S MAIDEN NAME Lillian YOUNG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 9-3-42 to 1-10-46		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell Carcinoma, with 1919 DUE TO Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 April , 19 58 , to 12 August , 19 58 , that I last saw the deceased alive on 11 August , 19 58 , and that death occurred at 2:30 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W.D. Hooper		ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 8-12-58	
PHYSICIAN'S NAME (Type) W.D. HOOPER, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR AUG 14 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

For Use by

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL PLACE

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL PLACE

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

CERTIFICATE OF DEATH

09329

Reg. Dist. No.

9334

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland c. LENGTH OF STAY IN lb 9 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY B. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harman 02X-2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle S Last Vawter		4. DATE OF DEATH Month Aug. Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 02 Days X Hours 2 Min.	IF UNDER 24 HRS. Months 02 Days X Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Green Spring, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME J. William Pike	
14. MOTHER'S MAIDEN NAME Margaret Denny		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Virginia Groseclose, Colesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X Arteriosclerotic Heart Dis DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gen'l Arteriosclerosis DUE TO (c) 20yrs		INTERVAL BETWEEN ONSET AND DEATH 10yrs 20yrs 20yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/19 , 19 58 , to 8/22 , 19 58 that I last saw the deceased alive on 8/22 , 19 58 , and that death occurred at 10:00 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE J. M. Warren		ADDRESS (Street, city or town, state) Laurel Md 8/22/58	
PHYSICIAN'S NAME (Type) John M. Warren		DATE SIGNED 8/22/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Highland, Howard CO., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Donaldson		24. REGISTRAR'S SIGNATURE Robert Donaldson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

31

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		Maryland		Baltimore		Heart Disease		Home		10:00 AM		[Signature]		[Signature]	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Signature	
Teacher		Married		White		Catholic		High School		None		Natural		Catholic Cemetery		Jan 15, 1931		10:00 AM		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer	
Jan 10, 1931		10:00 AM		Home		Heart Disease		Home		10:00 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

9335

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md. 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Green's Nursing Home</u>				d. STREET ADDRESS <u>10915 Jarboe Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>George Eugene</u> Middle <u>Vermett</u> Last				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Fred Vermett</u>				14. MOTHER'S MAIDEN NAME <u>Unknown CLAIRS MICHAUD.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>26409 4685</u>		17. INFORMANT <u>Mrs. John W. Wrathall</u>		Address <u>10915 Jarboe Ave. SS. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>NOV. 16, 1954</u> , to <u>AUG. 21, 1958</u> , that I last saw the deceased alive on <u>AUGUST 21, 1958</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVENUE AUG. 21, 1958</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>James A. Roberts</u> <u>SILVER SPRING, MARYLAND.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from this certificate as the burial-transit permit. Then please remove carbon paper and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9336

CERTIFICATE OF DEATH

Reg. Dist. No.

09331

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Wisconsin b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milwaukee	
c. LENGTH OF STAY IN 1b 17 days		d. STREET ADDRESS 4209 North 42nd Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robin Middle John Last Vilar		4. DATE OF DEATH Month August Day 2 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1954
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert L. Vilar		14. MOTHER'S MAIDEN NAME Nancy Samuelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no; or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Wilm's tumor with widespread metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1958 , to August 2, 1958 , that I last saw the deceased alive on August 2, 1958 , and that death occurred at 2:00A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 8-2-58 National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 8/5/58	
22c. NAME OF CEMETERY OR CREMATORY Milwaukee Cem.		22d. LOCATION (City, town, or county) (State) Wilwaukee, Wisc.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Aug 5 '58	
ADDRESS 7557 Wisconsin Ave. Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Alfred	

CERTIFICATE OF DEATH

Reg. Dist. No. 215

9337

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)	c. LENGTH OF STAY IN 1b 80 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 826 21st Street, N.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Thomas Middle Fulton Last VINES		4. DATE OF DEATH Month August Day 2 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1916
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skycap		10b. KIND OF BUSINESS OR INDUSTRY Airport Services	11. BIRTHPLACE (State or foreign country) No. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Douglas VINES	
14. MOTHER'S MAIDEN NAME Ada BUCHANAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII	
16. SOCIAL SECURITY NO. 577-26-2523		17. INFORMANT (W) Mrs. Myrtle Vines, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease, malignant 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH over 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 14 , 19 58 , to August 2 , 19 58 , that I last saw the deceased alive on August 2 , 19 58 , and that death occurred at 5:18 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 8-2-58 ACTUAL SIGNATURE C. U. Shilling M.D. PHYSICIAN'S NAME (Type) C. U. SHILLING LT MC USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-6-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W. E. JARVIS		ADDRESS Washington, D.C.	24a. REC'D BY REGISTRAR AUG 6 '58
24b. REGISTRAR'S SIGNATURE W. E. Jarvis		24c. REGISTRAR'S SIGNATURE W. E. Jarvis	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09333

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Lacka.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>1 wk</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scranton</u> <u>75x-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3707 Cherry Chase Lake Dr</u>			d. STREET ADDRESS <u>1619 Monsey Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>George Barron Vi Pond</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1878</u>		9. AGE (in years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Vi Pond</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Fulton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>071-09-7940</u>		17. INFORMANT <u>Mrs. M. H. H. - Mrs. M. H. H.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Scranton, Penna.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>9-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hills Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Scranton, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>			ADDRESS <u>Bethesda, Md.</u>		
24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9339

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>14 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>1616 Pershing Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Emma Platz Wadley</u>		First Middle Last		4. DATE OF DEATH <u>Aug 4 1958</u>		Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-15-1862</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Joseph Platz</u>				14. MOTHER'S MAIDEN NAME <u>Maria Ossinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nursing home Rechal</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Circulatory failure</u> 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of left hip</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>1 mo-8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerosis heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on bed room floor</u>					
20c. TIME OF INJURY Month, Day, Year <u>6/26 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Nursing home</u>		20f. (City or town) (County) (State) <u>Kensington Montg md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>8-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>Al. Leach</u>	
				DATE <u>AUG 6 '58</u>		24b. REGISTRAR'S SIGNATURE	

M

90

I

15

2

9340

CERTIFICATE OF DEATH

Item 14 Film 232 8-21-58 et

Reg. Dist. No. 09335

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		d. STREET ADDRESS <u>5211 Roosevelt St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Chester</u> Middle <u>Harner</u> Last <u>Harner</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 30, 1917</u>
9. AGE (In years last birthday) <u>40</u> yr.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mich.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Elijah Harner</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nelson Harner</u>	
17. INFORMANT <u>Nelson Harner</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO <u>Atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute acquired hemolytic anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>July 22, 1958</u> , to <u>August 16, 1958</u> , that I last saw the deceased alive on <u>August 16, 1958</u> , and that death occurred at <u>5:09 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Roger Rute, M.D.</u>		DATE SIGNED <u>3701 Conn. Ave. NW 16 Aug. 1958</u>	
PHYSICIAN'S NAME (Type) <u>C. Roger Rute, M.D.</u>		<u>Washington, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 19, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>I. P. Ives, M.D.</u>		ADDRESS <u>2847 Wilson Blvd, ARLINGTON, VA</u>	
24a. REC'D BY REGISTRAR <u>AUG 19 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director. Page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9341

09336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Mon Tg</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mon Tg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x GAITHERSBURG</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 MEEM AVE.</u>				d. STREET ADDRESS <u>15 MEEM AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>WALLACE</u> Last <u>WARNER</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 31, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>KEEN, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>REV. WM WALLACE</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET ELDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>REV. J.O. WARNER</u>				Address <u>5 MEEM AVE. GAITHERSBURG, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Hypertension Arteriosclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>Aug. 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 18</u> , 19 <u>58</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Luciano I. Leal</u> M.D.				ADDRESS (Street, city or town, state) <u>GaitHERSBURG MD.</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>Luciano I. Leal M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>THE S.H. NIVESCO</u>				ADDRESS <u>3901 14th St N.W. WASHINGTON D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1931

REG. FILE NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

CERTIFICATE OF DEATH

09337

Reg. Dist. No.

9342

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3903 Leland Street				d. STREET ADDRESS 3903 Leland Street			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle B Last WEBB				4. DATE OF DEATH Month August Day 5 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1870	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 11 Days 25	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Vermont	
13. FATHER'S NAME Samuel H. Brooks				14. MOTHER'S MAIDEN NAME Emma L. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-46-6110B		17. INFORMANT DeWitt C. Webb-husband-same as 2b	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, rt. severe DUE TO 334x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalised DUE TO 5 yrs + (c) 						INTERVAL BETWEEN ONSET AND DEATH 4 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auricular Fibrillation with congestive failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from Aug 1, 1958 , to Aug 5, 1958 , that I last saw the deceased alive on Aug 5, 1958 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart Clapp				ADDRESS (Street, city or town, state) 3921 Ingomar St N.W.			
PHYSICIAN'S NAME (Type) Stewart Clapp				DATE SIGNED 7-5-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 8/8/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 	
				DATE AUG 11 '58		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from this as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. RACE White		5. DATE OF BIRTH 1900		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH 1965		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. H. Harris	
13. SIGNATURE OF DECEASED J. H. Harris		14. SIGNATURE OF WITNESSES J. H. Harris		15. SIGNATURE OF REGISTRAR J. H. Harris	
16. SIGNATURE OF CLERK J. H. Harris		17. SIGNATURE OF JURY J. H. Harris		18. SIGNATURE OF JUDGE J. H. Harris	
19. SIGNATURE OF SHERIFF J. H. Harris		20. SIGNATURE OF CORONER J. H. Harris		21. SIGNATURE OF DISTRICT ATTORNEY J. H. Harris	
22. SIGNATURE OF COUNTY CLERK J. H. Harris		23. SIGNATURE OF CITY CLERK J. H. Harris		24. SIGNATURE OF STATE CLERK J. H. Harris	
25. SIGNATURE OF FEDERAL CLERK J. H. Harris		26. SIGNATURE OF POSTAL CLERK J. H. Harris		27. SIGNATURE OF AIR MAIL CLERK J. H. Harris	
28. SIGNATURE OF TELEGRAPH CLERK J. H. Harris		29. SIGNATURE OF TELEPHONE CLERK J. H. Harris		30. SIGNATURE OF RAILROAD CLERK J. H. Harris	
31. SIGNATURE OF STEAMSHIP CLERK J. H. Harris		32. SIGNATURE OF AIRCRAFT CLERK J. H. Harris		33. SIGNATURE OF MOTOR VEHICLE CLERK J. H. Harris	
34. SIGNATURE OF BOAT CLERK J. H. Harris		35. SIGNATURE OF FISH CLERK J. H. Harris		36. SIGNATURE OF GAME CLERK J. H. Harris	
37. SIGNATURE OF FOREST CLERK J. H. Harris		38. SIGNATURE OF PARK CLERK J. H. Harris		39. SIGNATURE OF RECREATION CLERK J. H. Harris	
40. SIGNATURE OF CULTURAL CLERK J. H. Harris		41. SIGNATURE OF ARTS CLERK J. H. Harris		42. SIGNATURE OF LETTERS CLERK J. H. Harris	
43. SIGNATURE OF MUSIC CLERK J. H. Harris		44. SIGNATURE OF THEATRE CLERK J. H. Harris		45. SIGNATURE OF RADIO CLERK J. H. Harris	
46. SIGNATURE OF TELEVISION CLERK J. H. Harris		47. SIGNATURE OF FILM CLERK J. H. Harris		48. SIGNATURE OF PHOTOGRAPHY CLERK J. H. Harris	
49. SIGNATURE OF BOOKS CLERK J. H. Harris		50. SIGNATURE OF PUBLICATIONS CLERK J. H. Harris		51. SIGNATURE OF PERIODICALS CLERK J. H. Harris	
52. SIGNATURE OF NEWS CLERK J. H. Harris		53. SIGNATURE OF MAGAZINES CLERK J. H. Harris		54. SIGNATURE OF JOURNALS CLERK J. H. Harris	
55. SIGNATURE OF BOOKS AND PERIODICALS CLERK J. H. Harris		56. SIGNATURE OF PUBLICATIONS AND PERIODICALS CLERK J. H. Harris		57. SIGNATURE OF PERIODICALS AND PUBLICATIONS CLERK J. H. Harris	
58. SIGNATURE OF NEWS AND PUBLICATIONS CLERK J. H. Harris		59. SIGNATURE OF MAGAZINES AND PUBLICATIONS CLERK J. H. Harris		60. SIGNATURE OF JOURNALS AND PUBLICATIONS CLERK J. H. Harris	
61. SIGNATURE OF BOOKS AND PERIODICALS CLERK J. H. Harris		62. SIGNATURE OF PUBLICATIONS AND PERIODICALS CLERK J. H. Harris		63. SIGNATURE OF PERIODICALS AND PUBLICATIONS CLERK J. H. Harris	
64. SIGNATURE OF NEWS AND PUBLICATIONS CLERK J. H. Harris		65. SIGNATURE OF MAGAZINES AND PUBLICATIONS CLERK J. H. Harris		66. SIGNATURE OF JOURNALS AND PUBLICATIONS CLERK J. H. Harris	
67. SIGNATURE OF BOOKS AND PERIODICALS CLERK J. H. Harris		68. SIGNATURE OF PUBLICATIONS AND PERIODICALS CLERK J. H. Harris		69. SIGNATURE OF PERIODICALS AND PUBLICATIONS CLERK J. H. Harris	
70. SIGNATURE OF NEWS AND PUBLICATIONS CLERK J. H. Harris		71. SIGNATURE OF MAGAZINES AND PUBLICATIONS CLERK J. H. Harris		72. SIGNATURE OF JOURNALS AND PUBLICATIONS CLERK J. H. Harris	
73. SIGNATURE OF BOOKS AND PERIODICALS CLERK J. H. Harris		74. SIGNATURE OF PUBLICATIONS AND PERIODICALS CLERK J. H. Harris		75. SIGNATURE OF PERIODICALS AND PUBLICATIONS CLERK J. H. Harris	
76. SIGNATURE OF NEWS AND PUBLICATIONS CLERK J. H. Harris		77. SIGNATURE OF MAGAZINES AND PUBLICATIONS CLERK J. H. Harris		78. SIGNATURE OF JOURNALS AND PUBLICATIONS CLERK J. H. Harris	
79. SIGNATURE OF BOOKS AND PERIODICALS CLERK J. H. Harris		80. SIGNATURE OF PUBLICATIONS AND PERIODICALS CLERK J. H. Harris		81. SIGNATURE OF PERIODICALS AND PUBLICATIONS CLERK J. H. Harris	
82. SIGNATURE OF NEWS AND PUBLICATIONS CLERK J. H. Harris		83. SIGNATURE OF MAGAZINES AND PUBLICATIONS CLERK J. H. Harris		84. SIGNATURE OF JOURNALS AND PUBLICATIONS CLERK J. H. Harris	
85. SIGNATURE OF BOOKS AND PERIODICALS CLERK J. H. Harris		86. SIGNATURE OF PUBLICATIONS AND PERIODICALS CLERK J. H. Harris		87. SIGNATURE OF PERIODICALS AND PUBLICATIONS CLERK J. H. Harris	
88. SIGNATURE OF NEWS AND PUBLICATIONS CLERK J. H. Harris		89. SIGNATURE OF MAGAZINES AND PUBLICATIONS CLERK J. H. Harris		90. SIGNATURE OF JOURNALS AND PUBLICATIONS CLERK J. H. Harris	
91. SIGNATURE OF BOOKS AND PERIODICALS CLERK J. H. Harris		92. SIGNATURE OF PUBLICATIONS AND PERIODICALS CLERK J. H. Harris		93. SIGNATURE OF PERIODICALS AND PUBLICATIONS CLERK J. H. Harris	
94. SIGNATURE OF NEWS AND PUBLICATIONS CLERK J. H. Harris		95. SIGNATURE OF MAGAZINES AND PUBLICATIONS CLERK J. H. Harris		96. SIGNATURE OF JOURNALS AND PUBLICATIONS CLERK J. H. Harris	
97. SIGNATURE OF BOOKS AND PERIODICALS CLERK J. H. Harris		98. SIGNATURE OF PUBLICATIONS AND PERIODICALS CLERK J. H. Harris		99. SIGNATURE OF PERIODICALS AND PUBLICATIONS CLERK J. H. Harris	
100. SIGNATURE OF NEWS AND PUBLICATIONS CLERK J. H. Harris		101. SIGNATURE OF MAGAZINES AND PUBLICATIONS CLERK J. H. Harris		102. SIGNATURE OF JOURNALS AND PUBLICATIONS CLERK J. H. Harris	

1. Name of Deceased
2. Sex
3. Age
4. Race
5. Date of Birth
6. Place of Birth
7. Date of Death
8. Time of Death
9. Place of Death
10. Cause of Death
11. Manner of Death
12. Signature of Physician
13. Signature of Deceased
14. Signature of Witnesses
15. Signature of Registrar
16. Signature of Clerk
17. Signature of Jury
18. Signature of Judge
19. Signature of Sheriff
20. Signature of Coroner
21. Signature of District Attorney
22. Signature of County Clerk
23. Signature of City Clerk
24. Signature of State Clerk
25. Signature of Federal Clerk
26. Signature of Postal Clerk
27. Signature of Air Mail Clerk
28. Signature of Telegraph Clerk
29. Signature of Telephone Clerk
30. Signature of Railroad Clerk
31. Signature of Steamship Clerk
32. Signature of Aircraft Clerk
33. Signature of Motor Vehicle Clerk
34. Signature of Boat Clerk
35. Signature of Fish Clerk
36. Signature of Game Clerk
37. Signature of Forest Clerk
38. Signature of Park Clerk
39. Signature of Recreation Clerk
40. Signature of Cultural Clerk
41. Signature of Arts Clerk
42. Signature of Letters Clerk
43. Signature of Music Clerk
44. Signature of Theatre Clerk
45. Signature of Radio Clerk
46. Signature of Television Clerk
47. Signature of Film Clerk
48. Signature of Photography Clerk
49. Signature of Books Clerk
50. Signature of Publications Clerk
51. Signature of Periodicals Clerk
52. Signature of News Clerk
53. Signature of Magazines Clerk
54. Signature of Journals Clerk
55. Signature of Books and Periodicals Clerk
56. Signature of Publications and Periodicals Clerk
57. Signature of Periodicals and Publications Clerk
58. Signature of News and Publications Clerk
59. Signature of Magazines and Publications Clerk
60. Signature of Journals and Publications Clerk
61. Signature of Books and Periodicals Clerk
62. Signature of Publications and Periodicals Clerk
63. Signature of Periodicals and Publications Clerk
64. Signature of News and Publications Clerk
65. Signature of Magazines and Publications Clerk
66. Signature of Journals and Publications Clerk
67. Signature of Books and Periodicals Clerk
68. Signature of Publications and Periodicals Clerk
69. Signature of Periodicals and Publications Clerk
70. Signature of News and Publications Clerk
71. Signature of Magazines and Publications Clerk
72. Signature of Journals and Publications Clerk
73. Signature of Books and Periodicals Clerk
74. Signature of Publications and Periodicals Clerk
75. Signature of Periodicals and Publications Clerk
76. Signature of News and Publications Clerk
77. Signature of Magazines and Publications Clerk
78. Signature of Journals and Publications Clerk
79. Signature of Books and Periodicals Clerk
80. Signature of Publications and Periodicals Clerk
81. Signature of Periodicals and Publications Clerk
82. Signature of News and Publications Clerk
83. Signature of Magazines and Publications Clerk
84. Signature of Journals and Publications Clerk
85. Signature of Books and Periodicals Clerk
86. Signature of Publications and Periodicals Clerk
87. Signature of Periodicals and Publications Clerk
88. Signature of News and Publications Clerk
89. Signature of Magazines and Publications Clerk
90. Signature of Journals and Publications Clerk
91. Signature of Books and Periodicals Clerk
92. Signature of Publications and Periodicals Clerk
93. Signature of Periodicals and Publications Clerk
94. Signature of News and Publications Clerk
95. Signature of Magazines and Publications Clerk
96. Signature of Journals and Publications Clerk
97. Signature of Books and Periodicals Clerk
98. Signature of Publications and Periodicals Clerk
99. Signature of Periodicals and Publications Clerk
100. Signature of News and Publications Clerk
101. Signature of Magazines and Publications Clerk
102. Signature of Journals and Publications Clerk

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4413 Everett St.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Jacob</u> Last <u>Weber</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1877</u>
9. AGE (In years, lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Joseph Weber</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shumcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Ralph Weber</u>		Address <u>4413 Everett St. Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Cerebrovascular arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>June 1958</u> <u>Aug 1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>Aug. 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 14</u> , 19 <u>58</u> , and that death occurred at <u>8:40</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Arthur E. Knaus</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Lee Funeral Home</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee</u>		24a. REC'D BY REGISTRAR <u>Aug 19 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knaus</u>			

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

8846

1

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. DATE OF DEATH [Illegible]</p>	
<p>7. TIME OF DEATH [Illegible]</p>		<p>8. PLACE OF DEATH [Illegible]</p>	
<p>9. CAUSE OF DEATH [Illegible]</p>		<p>10. MANNER OF DEATH [Illegible]</p>	
<p>11. SIGNATURE OF DECEASED [Illegible]</p>		<p>12. SIGNATURE OF WITNESS [Illegible]</p>	
<p>13. SIGNATURE OF DECEASED [Illegible]</p>		<p>14. SIGNATURE OF WITNESS [Illegible]</p>	
<p>15. SIGNATURE OF DECEASED [Illegible]</p>		<p>16. SIGNATURE OF WITNESS [Illegible]</p>	
<p>17. SIGNATURE OF DECEASED [Illegible]</p>		<p>18. SIGNATURE OF WITNESS [Illegible]</p>	
<p>19. SIGNATURE OF DECEASED [Illegible]</p>		<p>20. SIGNATURE OF WITNESS [Illegible]</p>	
<p>21. SIGNATURE OF DECEASED [Illegible]</p>		<p>22. SIGNATURE OF WITNESS [Illegible]</p>	
<p>23. SIGNATURE OF DECEASED [Illegible]</p>		<p>24. SIGNATURE OF WITNESS [Illegible]</p>	
<p>25. SIGNATURE OF DECEASED [Illegible]</p>		<p>26. SIGNATURE OF WITNESS [Illegible]</p>	
<p>27. SIGNATURE OF DECEASED [Illegible]</p>		<p>28. SIGNATURE OF WITNESS [Illegible]</p>	
<p>29. SIGNATURE OF DECEASED [Illegible]</p>		<p>30. SIGNATURE OF WITNESS [Illegible]</p>	
<p>31. SIGNATURE OF DECEASED [Illegible]</p>		<p>32. SIGNATURE OF WITNESS [Illegible]</p>	
<p>33. SIGNATURE OF DECEASED [Illegible]</p>		<p>34. SIGNATURE OF WITNESS [Illegible]</p>	
<p>35. SIGNATURE OF DECEASED [Illegible]</p>		<p>36. SIGNATURE OF WITNESS [Illegible]</p>	
<p>37. SIGNATURE OF DECEASED [Illegible]</p>		<p>38. SIGNATURE OF WITNESS [Illegible]</p>	
<p>39. SIGNATURE OF DECEASED [Illegible]</p>		<p>40. SIGNATURE OF WITNESS [Illegible]</p>	
<p>41. SIGNATURE OF DECEASED [Illegible]</p>		<p>42. SIGNATURE OF WITNESS [Illegible]</p>	
<p>43. SIGNATURE OF DECEASED [Illegible]</p>		<p>44. SIGNATURE OF WITNESS [Illegible]</p>	
<p>45. SIGNATURE OF DECEASED [Illegible]</p>		<p>46. SIGNATURE OF WITNESS [Illegible]</p>	
<p>47. SIGNATURE OF DECEASED [Illegible]</p>		<p>48. SIGNATURE OF WITNESS [Illegible]</p>	
<p>49. SIGNATURE OF DECEASED [Illegible]</p>		<p>50. SIGNATURE OF WITNESS [Illegible]</p>	
<p>51. SIGNATURE OF DECEASED [Illegible]</p>		<p>52. SIGNATURE OF WITNESS [Illegible]</p>	
<p>53. SIGNATURE OF DECEASED [Illegible]</p>		<p>54. SIGNATURE OF WITNESS [Illegible]</p>	
<p>55. SIGNATURE OF DECEASED [Illegible]</p>		<p>56. SIGNATURE OF WITNESS [Illegible]</p>	
<p>57. SIGNATURE OF DECEASED [Illegible]</p>		<p>58. SIGNATURE OF WITNESS [Illegible]</p>	
<p>59. SIGNATURE OF DECEASED [Illegible]</p>		<p>60. SIGNATURE OF WITNESS [Illegible]</p>	
<p>61. SIGNATURE OF DECEASED [Illegible]</p>		<p>62. SIGNATURE OF WITNESS [Illegible]</p>	
<p>63. SIGNATURE OF DECEASED [Illegible]</p>		<p>64. SIGNATURE OF WITNESS [Illegible]</p>	
<p>65. SIGNATURE OF DECEASED [Illegible]</p>		<p>66. SIGNATURE OF WITNESS [Illegible]</p>	
<p>67. SIGNATURE OF DECEASED [Illegible]</p>		<p>68. SIGNATURE OF WITNESS [Illegible]</p>	
<p>69. SIGNATURE OF DECEASED [Illegible]</p>		<p>70. SIGNATURE OF WITNESS [Illegible]</p>	
<p>71. SIGNATURE OF DECEASED [Illegible]</p>		<p>72. SIGNATURE OF WITNESS [Illegible]</p>	
<p>73. SIGNATURE OF DECEASED [Illegible]</p>		<p>74. SIGNATURE OF WITNESS [Illegible]</p>	
<p>75. SIGNATURE OF DECEASED [Illegible]</p>		<p>76. SIGNATURE OF WITNESS [Illegible]</p>	
<p>77. SIGNATURE OF DECEASED [Illegible]</p>		<p>78. SIGNATURE OF WITNESS [Illegible]</p>	
<p>79. SIGNATURE OF DECEASED [Illegible]</p>		<p>80. SIGNATURE OF WITNESS [Illegible]</p>	
<p>81. SIGNATURE OF DECEASED [Illegible]</p>		<p>82. SIGNATURE OF WITNESS [Illegible]</p>	
<p>83. SIGNATURE OF DECEASED [Illegible]</p>		<p>84. SIGNATURE OF WITNESS [Illegible]</p>	
<p>85. SIGNATURE OF DECEASED [Illegible]</p>		<p>86. SIGNATURE OF WITNESS [Illegible]</p>	
<p>87. SIGNATURE OF DECEASED [Illegible]</p>		<p>88. SIGNATURE OF WITNESS [Illegible]</p>	
<p>89. SIGNATURE OF DECEASED [Illegible]</p>		<p>90. SIGNATURE OF WITNESS [Illegible]</p>	
<p>91. SIGNATURE OF DECEASED [Illegible]</p>		<p>92. SIGNATURE OF WITNESS [Illegible]</p>	
<p>93. SIGNATURE OF DECEASED [Illegible]</p>		<p>94. SIGNATURE OF WITNESS [Illegible]</p>	
<p>95. SIGNATURE OF DECEASED [Illegible]</p>		<p>96. SIGNATURE OF WITNESS [Illegible]</p>	
<p>97. SIGNATURE OF DECEASED [Illegible]</p>		<p>98. SIGNATURE OF WITNESS [Illegible]</p>	
<p>99. SIGNATURE OF DECEASED [Illegible]</p>		<p>100. SIGNATURE OF WITNESS [Illegible]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF IDENTIFICATION ONLY. IT DOES NOT CONSTITUTE A GUARANTEE OF THE ACCURACY OF THE INFORMATION CONTAINED HEREIN. THE STATE OF MARYLAND DOES NOT WARRANT THE ACCURACY OF THE INFORMATION CONTAINED HEREIN. THE STATE OF MARYLAND DOES NOT WARRANT THE ACCURACY OF THE INFORMATION CONTAINED HEREIN.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9344

CERTIFICATE OF DEATH

Reg. Dist. No.

09339
215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)	c. LENGTH OF STAY IN 1b 2 Hr. 35 min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park 18X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS Unknown (P.O. Box 19)	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last WELLS		4. DATE OF DEATH Month August Day 4 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 August 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years lost birthday) yrs. 12 59 Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oscar A. WELLS		14. MOTHER'S MAIDEN NAME Gloria Ann CAMPBELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Official Navy Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Atelectasis, bilateral 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12 hrs 55 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4 August 19 58 , to 4 August 19 58 , that I last saw the deceased alive on 4 August 19 58 , and that death occurred at 3:05 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. C. Parke		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-7-58	
PHYSICIAN'S NAME (Type) J. C. PARKE, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-8-58	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) Lexington Park, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Mattingly, Leonardtown, Maryland		24a. REC'D BY REGISTRAR AUG 8 '58 24b. REGISTRAR'S SIGNATURE W. J. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 3. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051172XVI

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15, 1900</i></p>	
<p>5. Place of birth: <i>Baltimore, Md.</i></p>		<p>6. Date of death: <i>Dec 10, 1945</i></p>	
<p>7. Cause of death: <i>Heart disease</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	
<p>11. Date of filing: <i>Dec 15, 1945</i></p>		<p>12. Office use: <i>[Blank]</i></p>	

9196

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>10609 Lorain Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>CLAUDE LEE WHITE</u>		4. DATE OF DEATH <u>August 19 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-86</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clergy</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Milo White</u>		14. MOTHER'S MAIDEN NAME <u>Elvira Mallinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE EDEMA OF THE LUNGS</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>260x</u> (b) <u>ACUTE PELVIC PERITONITIS</u> DUE TO (c) <u>ACUTE INTESTINAL OBSTRUCTION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS, POSTENCEPHALITIC PARKINSONISM</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2-3 DAYS.</u> <u>5 DAYS.</u> <u>5-7 DAYS.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 AUG. 1958</u> to <u>19 AUG. 1958</u> that I last saw the deceased alive on <u>18 AUG. 1958</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.B. Snow</u>		DATE SIGNED <u>8/19/58</u>	
PHYSICIAN'S NAME (Type) <u>L.B. Snow</u>		ADDRESS (Street, city or town, state) <u>9013 FLOWER AVE. SILVER SPRING, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>Aug. 22, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Galtus</u>		ADDRESS <u>254 Carroll Ln NW DC</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After a death certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1908

Form D.H. 100

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1863	
Residence		Occupation		Cause of Death		Place of Death	
123 Main St, Baltimore, Md		Teacher		Heart Disease		Home	
Date of Death		Time of Death		Physician		Burial Place	
Jan 15, 1908		10:30 AM		Dr. J. Smith		Catholics	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Witness	
J. Smith		A. B. Doe		C. D. E		F. G. H	
Official Seal		Official Seal		Official Seal		Official Seal	

RECEIVED
JAN 16 1908
BALTIMORE, MD
DEPARTMENT OF HEALTH

9345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3720 Upton Street, N. W.	
3. NAME OF DECEASED (Type or print) First Middle Last MarieTTA (Name) J Wilde		4. DATE OF DEATH Month Day Year August 14 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1889
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arthur W. Jones		14. MOTHER'S MAIDEN NAME Lenora Hawkes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Carcinoma of thyroid DUE TO AND Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 1 Mo Yrs Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15, 1958 to August 14, 1958 , that I last saw the deceased alive on August 14, 1958 , and that death occurred at 6:21 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-15-58 ACTUAL SIGNATURE Mitchell T. Rabkin M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Mitchell T. Rabkin, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-18-58	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) BLADENSBURG MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO		24. REC'D BY REGISTRAR WASH D.C. ST. 12 DATE AUG 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur E. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9197

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. AND HOSPITAL</u>				d. STREET ADDRESS <u>7907 GARLAND AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>W</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>FE</u>		6. COLOR OR RACE <u>WH.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-25-1898</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OSTEOPATH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DANIEL WEAVER</u>				14. MOTHER'S MAIDEN NAME <u>FRANCIS AUKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>DAUGHTER</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage.</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <u>Generalized Arterio Sclerosis.</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>20 hr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John S. Ball</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>05 Aug 58</u>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pike Memorial Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ephrata Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walter</u>				ADDRESS <u>254 Carroll St NW DC</u>		24a. RECEIVED BY REGISTRAR DATE <u>AUG 19 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

11

9346

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 215

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>28 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital, NNMC, Bethesda, Md.</u>			d. STREET ADDRESS <u>42 Philadelphia Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jackie Terry WILLIAMS</u>			4. DATE OF DEATH Month Day Year <u>August 10 1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 21, 1937</u>		9. AGE (In years last birthday) <u>20</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>	
13. FATHER'S NAME <u>Albert WILLIAMS</u>			14. MOTHER'S MAIDEN NAME <u>Lucille MC KEEHAN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes 1-17-55 to pres.</u>		16. SOCIAL SECURITY NO. <u>379 36 0931</u>		17. INFORMANT <u>Official Navy Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fractures of 5th & 6th Cervical with injury to cord 28 days</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Dived from pier and struck sunken obstruction.</u>			
20c. TIME OF INJURY Month, Day, Year <u>6:00</u> Hour <u>7-13</u> Day <u>1958</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Breezy Point Beach</u>	
				20f. (City or town) (County) (State) <u>Breezy Point Calvert Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. BROSCHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>8-10-58</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jellico Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Jellico, Campbell Co., Tenn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>		ADDRESS <u>W. W. CHAMBERS CO., 1400 Chapin St., NW, Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur A. Kruetz</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 1 could be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Physician: _____

16. Signature of Nurse: _____

17. Signature of Undertaker: _____

18. Signature of Burial Place: _____

19. Signature of Funeral Home: _____

20. Signature of Cemetery: _____

21. Signature of Interment: _____

22. Signature of Burial: _____

23. Signature of Cremation: _____

24. Signature of Disposition: _____

25. Signature of Final Disposition: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from this as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09344

9198

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>18 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		1d. STREET ADDRESS <u>—</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First <u>Wilson</u> Middle <u>—</u> Last <u>—</u>		4. DATE OF DEATH <u>August 2 1958</u> Month <u>August</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-58</u>
9. AGE (In years lost birthday) <u>1 day</u>		10. UNDER 1 YEAR <u>—</u> IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roger Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Grace Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Father</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5 Congenital Heart Disease</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>32 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-1</u> , 19 <u>58</u> , to <u>8-2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-2</u> , 19 <u>58</u> , and that death occurred at <u>4:24</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stanley L. Wolf</u>		ADDRESS (Street, city or town, state) <u>2322 Blue Ridge Ave, Sil. Sp., Md.</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>8-2-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Disposal</u>		22b. DATE THEREOF <u>8-2-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>by Wash. San. & Hosp.</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>AUG 8 '58</u>			

2075314XV5

CERTIFICATE OF DEATH

1918

10-1-18

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
MARRIED
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

DATE OF INTERMENT
PLACE OF INTERMENT
NAME OF MINISTER
NAME OF CLERGYMAN

NAME OF PHYSICIAN
NAME OF SURGEON
NAME OF MIDWIFE
NAME OF NURSE

NAME OF CORONER
NAME OF JURY
NAME OF JUDGE
NAME OF CLERK

NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS

NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS

NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS

NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS

NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS
NAME OF WITNESS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Ass't Medical Examiner Notified and will approve.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9347

CERTIFICATE OF DEATH

09345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 814 SILVER SPRING AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES GEORGE WINSLOW		4. DATE OF DEATH Month AUGUST Day 19 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) butcher		10b. KIND OF BUSINESS OR INDUSTRY Dist. Grocery Store	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-09-9196	
17. INFORMANT Arthur J. Williamson		Address 5427 Taney Dr. Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Coronary and Hypertensive Cardiovascular Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH about 10 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Four Small Cerebrovascular accidents		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/25 , 19 57 , to 8/19 , 19 58 , that I last saw the deceased alive on Dec. 2 , 19 57 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin Isaacson		DATE SIGNED 8/19/58	
PHYSICIAN'S NAME (Type) Benjamin Isaacson		ADDRESS (Street, city or town, state) Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1958	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR AUG 20 '58		24b. REGISTRAR'S SIGNATURE Arthur J. Williamson	

CERTIFICATE OF DEATH

1927

DECEASED
NAME
AGE
SEX
RACE
BORN
DIED
PLACE
CITY
COUNTY
STATE

DATE OF DEATH
PLACE OF DEATH
CITY
COUNTY
STATE
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF BURIAL
CITY
COUNTY
STATE
DATE OF BURIAL
PLACE OF BURIAL
CITY
COUNTY
STATE
DATE OF BURIAL
PLACE OF BURIAL
CITY
COUNTY
STATE

FILED IN DEPARTMENT OF HEALTH - BALTIMORE 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9348

CERTIFICATE OF DEATH

Reg. Dist. No.

09346

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home		d. STREET ADDRESS 33 Quincu Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First AGNES Middle MAE Last WOLFINGER		4. DATE OF DEATH Month August Day 13 Year 1958		
5. SEX Fe	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 0 Days 28	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Andres Sonerson		14. MOTHER'S MAIDEN NAME Louisa Anderson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		
17. INFORMANT Carroll M. Wolfinger-sone-same as 2 d		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from OCT. 5 , 19 58 , to August 13 , 19 58 , that I last saw the deceased alive on August 12 , 19 58 , and that death occurred at 2 A M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 811 31st St. N. W. Washington, D. C. DATE SIGNED 8/13/58				
ACTUAL SIGNATURE E. W. Nealon Jr. M.D.				
PHYSICIAN'S NAME (Type) Stephen W. Nealon Jr.		1746 K St. N. W. Washington, D. C.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 8/13/58		
22c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		22d. LOCATION (City, town, or county) (State) Des Moines, Iowa		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		
24a. REC'D BY REGISTRAR AUG 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

CERTIFICATE OF DEATH

3248

NAME OF DECEASED MURPHY, JAMES		DATE OF BIRTH JAN 15 1881	
RESIDENCE 1234 E. BALTIMORE ST.		PLACE OF BIRTH BALTIMORE, MD.	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 20 1925		PLACE OF DEATH HOME	
TIME OF DEATH 10:30 AM		SEX MALE	
AGE 44		RACE WHITE	
EDUCATION HIGH SCHOOL		RELIGION METHODIST	
MARRIAGE MARRIED		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF WITNESSES J. H. SMITH, J. D. JONES	
SIGNATURE OF DECEASED JAMES MURPHY		SIGNATURE OF NEXT OF KIN J. H. SMITH	
SIGNATURE OF REGISTRAR J. H. SMITH		SIGNATURE OF CLERK J. H. SMITH	

RECEIVED
JAN 21 1925
BALTIMORE, MD.

9349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Nursing Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle Wootten Last Wootten				4. DATE OF DEATH Month August Day 13 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/73	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Henry Wootten				14. MOTHER'S MAIDEN NAME Margaret Elizabeth Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records Address Olney, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0 Arterio Sclerotic Heart Disease DUE TO Parkinson's Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture left hip (c) Fracture left hip PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tree at home fracture neck left femur 20c. TIME OF INJURY Month Day Year Hour a. m. 10:30 p. m. 58 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Peptonree Montgomery Md 21. I certify that I attended the deceased from 7/39 19 58 to 8/13 19 58 that I last saw the deceased alive on 8/11 19 58 , and that death occurred at 4:00 p.m. from the causes and on the date stated above. ACTUAL SIGNATURE J. W. Bird M.D. Sandy Spring DATE SIGNED 8/13/58 PHYSICIAN'S NAME (Type) J. W. Bird, M. D. ADDRESS Sandy Spring, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 15, 1958 22b. DATE THEREOF Aug 15, 1958 22c. NAME OF CEMETERY OR CREMATORY Long Hill Cem 22d. LOCATION (City, town, or county) (State) Laurel Md 23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Canaldon, Laurel, Md ADDRESS Laurel, Md 24a. REC'D BY REGISTRAR Aug 20 '58 24b. REGISTRAR'S SIGNATURE Charles S. Howard							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09348

9350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS Box 77, Route #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howell Middle Louis Last Worthington		4. DATE OF DEATH Month August Day 9 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1899
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Worthington		14. MOTHER'S MAIDEN NAME Susie Hammond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertension and arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 days many years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21 , 19 58 , to August 9 , 19 58 , that I last saw the deceased alive on August 9 , 19 58 , and that death occurred at 3:10 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED			
ACTUAL SIGNATURE Bertrand R. Galt		M.D. Sykesville, Maryland	
PHYSICIAN'S NAME (Type) B. R. Galt, M. D., Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-13-58	
22c. NAME OF CEMETERY OR CREMATORY Bushy Park		22d. LOCATION (City, town, or county) (State) Crookville, Howard, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ruthie H. Haight		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR AUG 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

[illegible]

9351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jettye Middle Ellen Last Wyatt				4. DATE OF DEATH Month 22 Day August Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1889	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David W. Gilliam				14. MOTHER'S MAIDEN NAME Ellen Pace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myelocytic leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 27 , 19 58 to August 22 , 19 58 , that I last saw the deceased alive on August 22 , 19 58 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-23-58 ACTUAL SIGNATURE Habeeb Bacchus M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Habeeb Bacchus, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8/23/58		Maple Lawn Park		Paducah, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

2

50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09350

9352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9813 ROSENSTEEL AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERBERT Middle OSBORNE Last YARDLEY		4. DATE OF DEATH Month AUGUST Day 7 Year 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/89
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WRITER AND AUTHOR		10b. KIND OF BUSINESS OR INDUSTRY WORTHINGTON, INDIANA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT KIRKBRIDE YARDLEY		14. MOTHER'S MAIDEN NAME MARY EMMA OSBORNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 215-26-3709	
17. INFORMANT Mrs. Edna R. Yardley, 9813 Rosensteel Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO 7 days (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 2 1958 to Aug 7, 1958 that I last saw the deceased alive on Aug 7, 1958 , and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md DATE SIGNED 8/7/58 ACTUAL SIGNATURE John J. Curry M.D. PHYSICIAN'S NAME (Type) JOHN J. CURRY			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/11/58	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey		24a. REC'D BY REGISTRAR DATE AUG 11 '58	
24b. REGISTRAR'S SIGNATURE W. Beach			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached from this certificate and taken to the funeral home. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

09351

Reg. Dist. No.

9353

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. STREET ADDRESS <u>19302 Sutton Pl.</u>			
3. NAME OF DECEASED (Type or print) (also known as <u>Annie</u>) <u>Anna Catherine Young</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28, 1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fleishell</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>577-10-5191 D</u>		17. INFORMANT <u>Eugene W Young, 9300 Sutton Pl. Md.</u> Address <u>Silver Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Aug 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 3</u> , 19 <u>58</u> , and that death occurred at <u>9:05</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u> DATE SIGNED <u>8/3/58</u> ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D. <u>Silver Spring, Md.</u> PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>AUG 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

